STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Daytona Juvenile Residential Facility

TrueCore Behavioral Solutions, LLC
(Contract Provider)
1386 Indian Lake Road
Daytona Beach, Florida 32124-1001

Review Date(s): July 14-17, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions which do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator which result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator which typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

The Bureau of Monitoring and Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Kristine Harshaw, Office of Accountability and Program Support, Lead Reviewer (Standard Five & Interviews)
Lea Herring, Office of Program Accountability and Program Support, Regional Monitor (Standard One)
Mike Marino, Office of Program Accountability and Program Support, Regional Monitor (Standard Two & Interviews)
Jillian Lewandowski, DJJ Probation, Circuit 7, Assistant Chief Probation Officer (Standard Three)
Renette Crosby, Office of Program Accountability and Program Support, Operations Review Specialist (Standard Four)

Program Name: Daytona Juvenile Residential Facility
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Volusia County / Circuit 7
Review Date(s): July 14-17, 2020

MQI Program Code: 1226
Contract Number: R2107
Number of Beds: 32
Lead Reviewer Code: 187

This review was conducted in accordance with FDJJ-2000 (Contract Management and Program Monitoring and Quality Improvement Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Assessment and Performance Plan, (3) Mental Health and Substance Abuse Services, (4) Health Services, and (5) Safety and Security, which are included in the Residential Standards.

Overall Rating Summary

The following limited and/or failed indicators require immediate corrective action.

Limited Ratings	Failed Ratings
1.14 Internal Alerts System and Alerts (JJIS)*	
3.06 Mental Health and Substance Abuse Treatment	
3.13 Suicide Prevention Training *	
3.15 Crisis Assessments *	

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening *	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Provision of an Abuse-Free Environment *	Satisfactory
1.04	Management Response to Allegations *	Satisfactory
1.05	Incident Reporting (CCC) *	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	Pre-Service/Certification Requirements *	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	Internal Alerts System and Alerts (JJIS)*	Limited
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory
1.20	Recreation and Leisure Activities	Satisfactory

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	Residential Assessment for Youth (RAY)	Satisfactory
2.08	Youth Needs Assessment Summary (YNAS)	Satisfactory
2.09	Performance Plan Development, Goals and Transmittal *	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory
2.13	Members of Treatment Team	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory
2.16	Career Education	Satisfactory
2.17	Educational Access	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory
2.22	Safety Planning Process for Youth	Satisfactory

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Standard 3: Mental Health and Substance Abuse Services
Residential Rating Profile

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Limited
3.07	Treatment and Discharge Planning *	Satisfactory
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Limited
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Limited
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Satisfactory

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Satisfactory
4.05	Healthcare Admission & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	Designated Health Authority/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Illness/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control	Satisfactory
4.18	Prenatal Care/Education	Satisfactory
4.19	Licensed Medical Staff*	Satisfactory

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Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handling and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Elements of the Water Safety Plan, Staff Training, and Swim Test *	Non-Applicable
5.22	Visitation and Communication	Satisfactory
5.23	Search and Inspection of Controlled Observation Room	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Daytona Juvenile Residential Facility is a thirty-three-bed program, for thirteen to eighteen year old males, located in Daytona Beach, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides sex offender treatment services. In addition, the program fosters each youth by providing Pathways: A Guide Workbook for Youth Beginning Treatment, Roadmap to Recovery, Footprints – Steps to a Healthy Life, Anger Management for Substance Abuse and Mental Health Clients, Conflict Resolution from the Inside Out, Transforming Anger to Personal Power, Social Skills Lesson and Activities for grades seven through twelfth, Stress Management for Adolescents, 100 Interactive Activities for Mental Health/Substance Abuse Recovery, Creative Therapy, and Young Men's Work. Additional treatment services provided includes family and individual therapy, interventions, group therapy, and recreation therapy. Program administration at the time of the annual compliance review was comprised of a facility administrator and an administrative assistant.

Case management services are provided by three case managers, a community case manager, and a transitional case manager. Mental health staff at the program includes the director of clinical services, who serves as the designated mental health authority (DMHCA) and supervises three therapists and the recreational therapist. Medical services are offered seven days a week and are provided by the health services administrator, who oversees one license practical nurse (LPN). The program also includes the designated health authority (DHA) and the psychiatrist who are doctors contractually required to make weekly and bi-monthly visits, respectively, to the program to see youth based on their needs.

The program provides food services through a contracted food service provider. Medical services are offered seven days a week and are provided by one medical doctor who serves as the DHA, one full time registered nurse (RN), and one licensed practical nurse (LPN). Educational services are provided by the Volusia County School Board. The layout of the program includes two primary buildings including an administrative and education portable and a brick building which houses the youth dorms, medical office, cafeteria, multi-purpose room, and staff offices. The program has twenty-two cameras capable of storing up to thirty days of footage, all of which were operational. At the time of the annual compliance review, the program had eight vacant positions including five Youth Care Worker I positions and three Youth Care Worker II positions.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates he or she exhibits no behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

Background screening is to be completed for staff, volunteers, contractors, and interns prior to the date of hire or services being provided. Ten new staff were hired during the annual compliance review period. A review of the Department's Background Screening Unit (BSU), Clearinghouse screenings, and personnel records were reviewed. All ten staff received background screenings with all staff screenings returned prior to the date of hire. A pre-employment assessment tool was completed for the six applicable direct-care workers, with a passing score. Reviewed documentation for each staff included the CCC Person Involvement Report, the Staff Verification System (SVS) module, Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) result. Staff were added to the program's Clearinghouse employment roster upon hire. An Annual Affidavit of Compliance with Level 2 Screening Standards was submitted by the program to the Department's BSU on December 12, 2019, meeting the annual requirement. Education staff at the program are funded through the Volusia County School Board who also submitted an Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on December 12, 2019.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background rescreening/resubmission is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant's personal profile page within the Clearinghouse.).	

The program has a written policy and procedures which addresses background screenings and five-year re-screenings of program staff. The program's policy states all staff will receive a background rescreening every five years from the date of hire. Two staff were applicable for a five-year background re-screening during the annual compliance review period. Both applicable staff were re-screened, as required; however, one of the background re-screenings was completed twelve months and two days prior to the staff's five-year anniversary date.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance

The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment.

- *The residential program shall post the Florida Abuse Hotline telephone number for youth under the age of eighteen and the Central Communications Center telephone number for youth 18 years of age and older telephone number.*
- *All allegations of child abuse or suspected child abuse shall be immediately reported to the Florida Abuse Hotline.*
- *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.*
- *The environment is free of physical, psychological, and emotional abuse (incorporating trauma responsive principles).*
- *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety, while also incorporating trauma responsive practices.*
- *The program shall complete or schedule a TRACE self-assessment.*

The program has a written policy and procedures addressing abuse and neglect reporting. The policy includes the steps to report alleged abuse or neglect of a youth at the program, a zero-tolerance policy regarding any abuse by staff, and staff are mandatory reporters. The Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers were observed to be posted throughout the facility. Staff are required to sign a code of conduct during the staff employment process. A review of eight staff records confirmed staff signed the code of conduct. The program had seventeen incidents with allegations against staff for improper conduct/computer misuse, violation of policy/rule, and an improper/excessive use of force. Fourteen incidents were allegations of abusive behavior by program staff. Ten of the fourteen incidents included a call to the Florida Abuse Hotline from the program. Review of the CCC reports documented no result for nine allegations, five were found substantiated, and three were unsubstantiated. The Department of Children and Families (DCF) investigate all reports to the Florida Abuse Hotline and any allegations of abuse, in addition to the program's internal investigations. The program provided documentation of the TRACE self-assessment in June 2020.

An interview with the assistant facility administrator (AFA) revealed the code of conduct includes the types of incidents which are against the policy, types of associated consequences, and response matrix; which include processes for coaching, oral, written, suspension, and termination. If there are instances of physical verbal or emotional abuse towards a youth, the incident is investigated internally and a determination is made by the facility administrator. If allegations are made, the staff is removed from youth contact until the investigation is completed. If there is a suspicion or allegation of abuse of a youth, then the program is responsible for notifying the Florida Abuse Hotline or the CCC within two hours. If the youth is eighteen years of age or older and alleging abuse, the youth is given unimpeded access to report the incident to the Florida Abuse Hotline and CCC. The AFA staff are trained on the

reporting process and the contact information for the Florida Abuse Hotline and CCC is posted throughout the facility. All seven interviewed youth reported feeling safe at the program. Six of the seven youth reported they have not been prohibited from calling abuse. One youth reported he was eighteen years of age and was told to make sure he was serious because he "could catch a charge." Five youth reported staff are respectful when speaking with youth, and two youth reported some staff are respectful. Three youth reported staff never used profanity, three stated occasionally, and one stated often. All seven youth reported they have never exchanged personal contact information with staff. All seven interviewed staff reported the supervisor is notified when a youth wants to call the Florida Abuse Hotline or CCC. Each of the staff reported never witnessing staff denying a youth an abuse call or staff using profanity, threats, intimidation, or humiliation language towards youth.

1.04 Management Response to Allegations (Critical)	Satisfactory Compliance
Management shall be cognizant of youth and staff needs and provide direction to each on how to access the Florida Abuse Hotline. There is evidence management takes immediate action to address incidents of physical, psychological, and emotional abuse.	

A review of the Department's Central Communications Center (CCC) reports during the annual compliance review period revealed seventeen incidents were reported regarding allegations against staff for improper actions which required a program response. Documentation of the program's management review reports reflected management took immediate action to address each applicable allegation. All allegations were addressed in each internal investigation reviewed and a corrective plan was initiated when necessary. Two of the six reports reviewed were pending results and two of the six reports had conclusion results which were not updated with the CCC. An interview with the assistant facility administrator revealed two staff have received disciplinary actions due to allegations of abuse.

1.05 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
The program shall notify the Department's Central Communications Center (CCC) within two hours of the incident occurring, or within two hours of any program staff becoming aware of the reportable incident.	

In the past six months, the program had twenty-five incidents reported to the Department's Central Communications Center (CCC), of which six were reviewed. Each incident was reported to the CCC within two hours of the incident or within two hours of the individual becoming aware of the incident. Two incidents involved sexual abuse, improper conduct, and felony arrest. The remaining reports included improper supervision, violation of policy, threats to staff, unnecessary use of force, and staff/youth relationship. All reviewed CCC reports were documented in the facility logbook. A review of youth grievances did not reflect any additional incidents which should have been reported to the CCC. There was an increase of incidents reported to the CCC during this annual compliance review period, as last annual compliance review period, eleven incidents were reported to the CCC. The program responded the increase was due to COVID-19 reports and a former disgruntled staff who made allegations against staff at the program.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory Compliance
The program uses physical intervention techniques in accordance with Florida Administrative Code. Any time staff uses a physical intervention technique, such as countermoves, control techniques, takedowns, or application of mechanical restraints (other than for regular transports), a PAR Incident Report is completed and filed in accordance with the Florida Administrative Code.	

In the past six months, the program had eleven incidents involving the use of Protective Action Response (PAR). Each of the six reviewed incident reports documented the PAR report was completed by the end of the staff member's workday; however, one report included a statement from staff involved and an administrative review conducted the next day. None of the incidents documented the use of mechanical restraints or any injuries to staff or youth. Each report documented a review by a PAR certified instructor or supervisory staff. Three of the six post-PAR interviews were conducted with the youth the day of the incident. Two of the remaining three post-PAR interviews were completed the following day and there was no post-PAR interview date documented for the last remaining incident. All six PAR incident reports were reviewed by the facility administrator or designee within seventy-two hours, as required. All PAR incidents were documented in a centralized binder organized by month. The program has an approved PAR plan which was signed by the Department and the Office of Staff Development and Training on March 28, 2019. The program's PAR rate during the annual compliance review period was 1.74, which is below the statewide Residential PAR rate of 2.28, which is an increase from the previous annual compliance review of 0.39. An interview with the assistant facility administrator (AFA) revealed PAR reports are monitored daily in response to monitoring PAR incidents and use of force. Four of the seven interviewed staff reported engaging in a PAR incident and all staff expressed the importance of using alternative methods, such as verbal interventions, to PAR when engaging with youth.

1.07 Pre-Service/Certification Requirements (Critical)	Satisfactory Compliance
Residential contracted provider staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.	

Seven staff training records were reviewed for pre-service requirements. All seven staff completed the essential pre-service training which must be completed prior to any contact with youth to include cardiopulmonary resuscitation, first aid, automated external defibrillator (AED), ethics, Prison Rape Elimination Act (PREA), human trafficking, emergency procedures, child abuse reporting, restorative justice, and six hours of suicide prevention training, to include two hours of training in the Department's Learning Management System (SkillPro). In addition, each staff completed the required training such as gender response, positive performance, trauma-informed care trainings, and forty-hours of Protective Action Response (PAR) training. Five of the seven staff completed more than the required minimum of 120 hours of pre-service training. The two remaining staff are still within their first 180 days of employment. The program provided documentation to confirm the training instructors are qualified to deliver training provided for all staff certifications. The program submitted a list of pre-service training to the Office of Staff Development and Training (SD&T) to include course names, descriptions, objectives, and training hours on January 10, 2019, which was approved by SD&T on January 16, 2019. All training was documented in SkillPro within thirty days of training completion.

1.08 In-Service Training	Satisfactory Compliance
Residential contracted provider staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed. *Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.*	

Seven staff records were reviewed for in-service training. Each staff completed twenty-four hours of annual in-service training to include cardiopulmonary resuscitation, first aid, automated external defibrillator (AED), ethics, suicide prevention, and an eight-hour Protective Action Response (PAR) update trainings. Each staff completed Prison Rape Elimination Act (PREA), trauma-informed care, human trafficking for direct care staff, and stress management. Three of the seven reviewed records were for supervisory staff. Each supervisor completed more than the required eight hours of supervisory training with a forty-hour curriculum of On the Job Training (OJT) required when staff are promoted to a supervisor. Each supervisor received training in management, leadership, employee relations, communication skills, and fiscal training. All training was documented in the Department's Learning Management System (SkillPro). The program maintains an annual in-service training calendar, which is updated as necessary. A list of in-service trainings was submitted to the Office of Staff Development and Training (SD&T) to include course names, descriptions, objectives, and training hours. The in-service training plan was submitted to the Department on January 10, 2019 and approved by SD&T on January 16, 2019.

1.09 Grievance Process	Satisfactory Compliance
Program staff shall be trained on the program's youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility. *Completed grievances shall be maintained by the program for a minimum of twelve months.*	

The program has a written policy and procedures addressing the grievance process. The grievance procedures detail the three grievance phases to include the informal, formal, and appeal phases. The policy indicates the informal phase is an attempt to resolve disputes through informal communication such as verbal discussion among staff and youth. The program also has "Speak Out" forms and grievance forms available to youth to note any informal complaints. The formal phase includes the youth completing a grievance form which can include the assistance of a third party to help the youth to complete the grievance. According to policy, the formal review is processed by administrative staff, such as the facility administrator or assistant facility administrator, to be completed within seventy-two hours including a response back to the youth. Seven youth grievances completed within the last six months were reviewed. Each grievance documented the nature of the grievance, the date the grievance was submitted by the youth, the date of the response by staff, and a youth signature acknowledging the result. Five of the seven grievances reviewed documented the program responded the same day the grievance was submitted. One record had a one-day response and another record had a three-day response rate. All seven grievances included the youth's signature signifying an acceptance of the grievance result. None of the seven grievances reviewed went to an appeal phase. The program has maintained copies of the grievances for the previous twelve months.

An interview with the assistant facility administrator revealed youth have unimpeded access to grievance forms.

There is an attempt to resolve the grievance during the informal phase. If unsuccessful, then the grievance form is completed and dropped in the grievance box located inside the day room and on the dorm. The box is checked daily and the grievance is answered within seventy-two hours. If the youth disagrees with the findings, the grievance moves to the appeal phase and is reviewed by the facility administrator (FA) within seventy-hours. The FA's decision is final. Each of the seven interviewed youth indicated grievance forms are available, if needed. All of the youth reported assistance in filling a grievance out is provided as needed. All seven interviewed staff reported grievance forms are available to youth throughout the facility, three reported youth can request assistance, and one staff reported either the supervisor or program director reviews the grievance forms.

1.10 Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement a delinquency interventions for each youth. Interventions shall include evidence-based practices, promising practices, practices with demonstrated effectiveness, and any other delinquency interventions and treatment services approved by the Department. Staff whose regularly assigned job duties include the implementation of a specific delinquency intervention and/or curriculum must receive training in its effective implementation.	

The interventions utilized at the program include Pathways: A Guide Workbook for Youth Beginning Treatment, Roadmap to Recovery, Footprints – Steps to a Healthy Life, Anger Management for Substance Abuse and Mental Health Clients, Conflict Resolution from the Inside Out, Social Skills Lesson and Activities for grades seven through twelve, Stress Management for Adolescents, 100 Interactive Activities for Mental Health/Substance Abuse Recovery, Creative Therapy, and Young Men's Work. At the time of the annual compliance review, the program had three full-time and one part-time therapists, as well as two case managers who facilitated therapy groups. Each of the five reviewed staff records determined the staff had the required education, work experience, a training to deliver the intervention services provided. The program's activity schedule reflected the program provided structured, planned programming, and activities to include the delinquency interventions at least sixty percent of the youth's awake hours. A review of sign-in sheets confirmed groups were delivered, as required. Each of the seven reviewed performance plans addressed an identified need and youth are involved in an intervention to address the identified need. All seven youth records were reviewed for delinquency interventions participation.

1.11 Life and Social Skills Training Provided to Youth	Satisfactory Compliance
The program shall provide instruction focusing on developing life and social skill competencies in youth.	

Life skills training is provided utilizing Life Skills 225. Each week for one hour, youth attend a social and coping skills group which incorporates the life skills training. The youth also attend a separate group for an hour each week for conflict resolution and thinking, feelings, and behaviors. The program's activity schedule reflected groups are conducted each week. Group topics address life skills such as communication, interpersonal relationships, interactions, non-violent conflict resolution, anger management, and critical thinking including problem-solving and decision-making. All seven interviewed youth confirmed their participation in groups and

have demonstrated skills learned. A review of sign-in sheets confirmed groups were delivered, as required.

1.12 Restorative Justice Awareness for Youth	Satisfactory Compliance
The program shall provide activities or instruction intended to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability for youths' criminal actions and harm to others.	

The program conducts Impact of Crime (IOC) and Pathways groups to provide restorative justice awareness for youth to increase accountability for criminal actions and harm to others. Based on a review of documentation, restorative justice activities were conducted and planned as designed. A review of sign-in sheets confirmed groups were delivered, as required. Review of seven staff training records confirmed eligible staff were trained to conduct restorative justice awareness groups. The program has a victim wall in the case management area and the program utilizes a victim chair to represent the youth's victim as a reminder of the impact of their crime. The interview with the assistant facility administrator (AFA) confirmed the restorative justice groups available.

1.13 Gender-Specific Programming	Satisfactory Compliance
A residential commitment program shall provide delinquency interventions and treatment services which are gender-specific and focus on preparing youth to live responsibly in the community upon release from the program.	

The program utilizes Young Men's Work, Teen Relationships, and The Guy Book as the gender-specific programming provided to youth. Young Men's Work is a program for young men who are working together to solve problems without resorting to violence. The programming was included on the activity schedule. Young Men's Work curriculum contains twenty-six sections which includes objectives, an agenda, session, and exercises. Young Men's Work and Teen Relationships are conducted in an open group setting. Teen Relationships groups are held on Wednesday's and Young Men's Work groups are held on Monday's and Friday's. Both Young Men's Work and Teen Relationships are provided to all youth in the program. The gender-specific programming demonstrates a program model or component addressing the needs of the targeted gender. The program designs the services on the common characteristics of the target population.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Limited Compliance
The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status. *When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.*	

The program has a written policy and procedures addressing the alert system. The policy addresses how alerts are identified, documented, updated, and communicated with staff. The program maintains an internal alert system which is easily accessible to program staff to ensure they are aware of any security concerns, safety risks, health-related concerns, allergies, or special diets. The alert board contains each youth's picture, as well as the colored pins associated with the alert are located in the staff briefing room. The various levels of alerts are represented by various colors and includes sports restrictions, medical issues, gang affiliation, mental health-suicide precautions, escape risk, security risk, violent behavior, or special alert. The program's internal alert list was compared to the Department's Juvenile Justice Information System (JJIS) alerts. Mental health and medical alerts were reviewed during the annual compliance review and found several of the closed alerts were closed several weeks or months after the alert end date in JJIS. Three of the five suicide risk alerts were closed timely when the youth was removed from suicide precautions. One alert was updated sixty days after the youth was removed from precautionary observation and one alert was updated seventy-six days after the youth was removed from precautionary observation. A review of the facility logbook determined security alerts, mental health/suicide alerts, youth on close watch, and youth on precautionary observation were documented, as required.

An interview with the assistant facility administrator revealed identified safety and security risks identified during the admission are reviewed with staff during shift briefings and the information is then transposed to the internal alert board. The youth with mental health/substance abuse alerts of any type are elevated risks and are listed in the logbook, as well as on the internal alert board, and all staff are briefed daily during shift briefings. Youth food allergies are identified during a review of the youth's Electronic Commitment Packet (ECP) for any allergies or any medical concerns and documented on the internal alert board. Any new diagnosis is entered into JJIS, as well as the internal alert board. Any youth with a food allergy is shared with the contracted food services provider. Medical alerts are identified during a review of the youth's ECP for any medical concerns and the information is put on the internal alert board. Any new diagnosis is entered into JJIS, as well as the internal alert board. All information is entered and/or closed in JJIS by the assigned department, as well as updated as when changes are needed. Alerts are reviewed daily during shift briefings and morning meetings. All seven interviewed staff indicated there were no issues in receiving youth alerts. Four staff mentioned the alert board posted in the administrative hall and six staff reported various resources such as department heads, briefings, logbook, and treatment teams.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance
The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files: • *An individual healthcare record.* • *An individual management record.*	

The program maintains separate youth records to include an individual healthcare, case management, and mental health records for all youth. Seven youth case management records were reviewed. Each case management record contained a tab with the required information to include the youth's name, Department identification number, date of birth, county of residence, and the youth's committing offense. Each individual case management record contained the required sections to include legal information, demographic and chronological information, correspondence, case management and treatment team activities, and miscellaneous. Each record was labeled "Confidential" and records were observed to be secured in either a locked file cabinet labeled "Confidential" or a locked room not assessable to youth.

1.16 Youth Input	Satisfactory Compliance
The program has a formal process to promote constructive input by youth.	

The program has a formal process to promote constructive input by youth to include monthly youth committee meetings, youth advisory board, youth surveys, and "Speak Out" forms available to youth, as well as grievances and treatment team meetings. A review of meeting minutes confirmed youth community meetings were held twice each month and the youth advisory board meetings were held monthly. An interview with the assistant facility administrator confirmed the youth input practices. All seven interviewed youth explained how youth input is incorporated in the program.

1.17 Advisory Board	Satisfactory Compliance
The program has a community support group or advisory board meeting at least every ninety to 120 days. The program director solicits active involvement of interested community partners.	

The program has an established Community Advisory Board which consists of the facility administrator or designee, law enforcement representative, judiciary staff, community partners, individuals from the business community, school board, faith community, and the lesbian, gay, bisexual, transgender, queer or questioning, and intersex (LGBTQI) community. The advisory board also includes a victim advocate coordinator and parent/guardians of youth who were previously involved in the juvenile justice system. Documentation of sign-in sheets, agendas, and minutes were reviewed which reflected Community Advisory Board meetings were conducted quarterly, as required. It is noted the meetings were scheduled for ninety-day increments.

The assistant facility administrator reported the Community Advisory Board is comprised of members from the following organizations: Neighbor to Families, the Department of Children and Families (DCF), Volusia Regional Juvenile Detention Center, Community Partnership for Children, Volusia County School Board, Volusia County Law Enforcement, Volusia County Judiciary, local businesses, faith community, victim advocate/services, parent/guardian whose child was previously involved in the juvenile justice system, LGBTQI Outreach, United Way, &

Stewart Marchman Act Behavioral. A meeting was held December 12, 2019; however, the March 26 and June18,2020 meetings were cancelled due to the COVID-19 pandemic.

1.18 Program Planning	Satisfactory Compliance
The program uses data to inform their planning process and to ensure provisions for staffing.	

The program has a policy and procedures addressing staff communication, opportunities to provide input, and feedback. Surveys are completed with the youth, parent/guardians, and staff. The information from the surveys is reviewed, considered, and shared during the general staff meetings. Weekly staff meetings provide staff with an opportunity to provide input and feedback regarding the operation and areas of improvement of the facility. Staff meetings and the results of these meetings are entered into a database with results compiled by corporate staff. The Comprehensive Accountability Report (CAR) report is shared with staff in All Staff meetings to discuss decreasing recidivism of released youth.

The assistant facility administrator (AFA) reported the program retains and minimizes program issues by having an employee of the month, monthly drawings and employee recognition, safety committee where staff nominate employees with safe work habits, and pot-luck dinners for staff. The AFA reported there are daily shift briefings held prior to all shifts to discuss the current events of the program. There are also weekly supervision meetings for clinical staff, and monthly department meetings for case management staff and shift supervisors. The program also facilitates monthly “All Staff” meetings to apprise the staff of changes or information sharing. All seven interviewed staff reported staff meetings are held.

Two staff reported meetings are held bi-weekly, four staff reported monthly, and five reported bi-weekly or the second Wednesday of the month. Each staff interviewed described topics discussed during staff meetings. One staff reported information such as the program annual reports and/or youth/parent surveys were discussed during staff meetings. When asked how communication is among staff at the program, four staff reported very good, two staff said good, and one stated fair. All staff indicated the ability to provide feedback regarding the facility/program operations to administration.

1.19 Staff Performance	Satisfactory Compliance
The program ensures a system for evaluating staff, at least annually, based on established performance standards.	

The program has a written policy and procedures addressing a system for evaluating staff, performance standards, and frequency of evaluations. Evaluations for staff are completed annually. A sample of staff performance evaluations were reviewed for a variety of staff positions. Evaluations were conducted on an annual basis and include job specific performance standards. Performance standards matched the job descriptions for each staff and included job specific requirements of the position. The assistant facility administrator reported staff are evaluated annually in October. One of the seven staff interviewed reported annual evaluations and six staff reported other (every three months, every six months, and quarterly).

1.20 Recreation and Leisure Activities	Satisfactory Compliance
The program shall provide a variety of recreation and leisure activities.	

The program provides a variety of recreation and leisure activities. A review of the activity schedule found it includes recreation and leisure activities. The program has a recreational therapist who meets all requirements. Logbooks were reviewed for recreational activity which confirmed this practice. A review of seven youth records determined recreational therapy was included in each of the youth's performance plans. Recreation was observed during the annual compliance review. Seven interviewed youth expressed they were given the opportunity for different types of recreational activities each day for, at least, an hour. Seven interviewed staff explained several different types of recreational activities provided for the youth, listing both indoor and outdoor activities.

Standard 2: Assessment and Performance Plan

2.01 Initial Contacts to Parent/Guardian and Court Notification	Satisfactory Compliance
The program notifies the youth's parent/guardian by telephone within twenty-four hours of the youth's admission, by written notification within forty-eight hours of admission, and notify the youth's committing court, assigned juvenile probation officer (JPO) and post residential services counselor (if applicable) in writing within five working days of any admission.	

The program has a written policy and procedures addressing the notification of a youth's parent/guardian and committing court upon admission to the program. Seven youth case management records were reviewed, of which six were applicable for admission notifications (one youth was admitted prior to the last annual compliance review). All applicable records documented telephone notifications were made to the parent/guardian within twenty-four hours of admission. Each applicable record contained written notification to the youth's parent/guardian within forty-eight hours, notifying them of their youth's arrival to the program. Each applicable record contained supporting documentation of written notification sent to the youth's committing court and assigned juvenile probation officer (JPO) within a day of the youth's admission.

2.02 Youth Orientation	Satisfactory Compliance
The program shall provide each youth an orientation to the program rules, expectations, goals of the program, and services applicable to youth, to begin within the day of, or prior to, the youth's admission.	

The program has a policy and procedures to provide each youth an orientation to the program on the day of admission. The program utilizes an orientation checklist, which lists services available, the youth's responsibilities, daily schedule, contraband information, hygiene, dress code, emergency procedures, access to the Florida Abuse Hotline and the Central Communications Center (CCC), availability of and access to medical and mental health services, and information regarding the program's behavior management system. The initial intake also includes information regarding room assignment, introduction to the staff, review of anticipated length of stay, and review of the physical design of the facility. Seven case management records were reviewed, six of which were applicable for orientation. The applicable records contained documentation confirming each youth received an orientation on the day of admission, as well as a student handbook, which further explained program rules, expectations, and other pertinent information. Each applicable record contained an orientation checklist completed upon admission, which was signed by both the youth and staff. All seven interviewed youth reported they received an orientation covering program rules and expectations upon admission. There were no new admissions to observe during the annual compliance review.

2.03 Written Consent of Youth Eighteen Years or Older	Satisfactory Compliance
The program obtains written consent of any youth eighteen years of age or older, unless the youth is incapacitated and has a court-appointed guardian, before providing or discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.	

Two of the seven reviewed case management records reviewed were applicable for written consent of youth eighteen years and older; therefore, one additional applicable record was reviewed. Each applicable record contained documentation, signed by the youth, giving consent to release physical or mental health screenings, assessments, or treatment information to the parent/guardian. In one record, it was noted the consent was signed upon the youth's admission, which was just prior to the youth's eighteenth birthday.

2.04 Classification Factors, Procedures, and Reassessment for Activities	Satisfactory Compliance
The program utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, as well as effective delivery of treatment services. Initial classification should be used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. *Youth are reassessed and reclassified, if warranted, prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments which may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

The program has a written policy and procedures regarding classification factors, procedures, and reassessment for activities. Seven youth case management were reviewed, of which were six were applicable for an initial classification. The remaining youth record was for a youth who was admitted to the program prior to the annual compliance review period. Each applicable record documented a pre-classification meeting, during which staff from various program departments addressed various classification factors in order to determine room and group assignments. The initial classification addressed the youth's physical characteristics, age, maturity, whether the youth has any special needs, history of violence, gang affiliation, criminal behavior, and sexual aggression or vulnerability to victimization, as well as risk for suicide, escape, security, and medical concerns. A new Victimization and Sexually Aggressive Behavior (VSAB) form was completed for each applicable youth, with five of six VSABs entered into the Department's Juvenile Justice Information System (JJIS) prior to the youth's room assignment. The remaining VSAB was entered a week after the youth's admission. Alerts related to classification were entered in JJIS for each youth, though three alerts were not entered timely.

The program has a written policy and procedures requiring risk assessments be completed prior to considering an increase in privileges or freedom of movement or to allow activities involving tools or instruments possibly used as potential weapons or means of escape. Participation in off-campus activities was not applicable at the time of the annual compliance review due to the COVID-19 pandemic. The program maintains a binder with risk assessments/reassessments, which is kept in master control. A review of the binder found the program completes risk assessments on each youth upon admission and reassessments on each youth monthly thereafter. An updated internal alert system is reviewed with staff daily during shift briefings, informing staff of youth who are security or safety risks, including escape risks, suicide or other

mental health risks, medical risks, sexual predator risks, and other assaultive or violent behavior risks.

The interim facility administrator interview stated youth characteristics are reviewed prior to arrival and during a classification meeting to determine the most appropriate placement or sleeping quarters for youth. The interim facility administrator also stated treatment team members are assigned based on youth individual needs and characteristics.

2.05 Gang Identification: Notification of Law Enforcement	Satisfactory Compliance
The program shall gather information on gangs, (e.g., gang members, tattoos, other body markings) and share this information with law enforcement.	

None of the seven reviewed youth case management records were applicable for youth with gang affiliations; therefore, the program's two applicable youth records were reviewed. Case management records for the two applicable youth and a binder kept to document gang services were reviewed. The records and binder documented written notifications, by e-mail, were made by the program to local law enforcement, the youth's home county law enforcement, the juvenile probation officer, and education provider for each youth. A review of the Department's Juvenile Justice Information System (JJIS) found the program entered gang alerts for each youth.

2.06 Gang Identification: Prevention and Intervention Activities	Satisfactory Compliance
A residential commitment program shall implement gang prevention and intervention strategies. The residential commitment program shall provide intervention strategies when youth are identified as being a criminal street gang member, are affiliated with any criminal street gang, or are affiliated with any criminal street gang, or are at high risk of gang involvement.	

The program has a policy and procedures for youth who have gang affiliations to receive services to educate youth regarding gang activity and provide youth the opportunity to develop a plan to disaffiliate with a criminal street gang. The program utilizes assessments, the classification process and the Department's Juvenile Justice Information System (JJIS) to identify youth requiring participation in the gang prevention or intervention activities. The interim facility administrator serves as the program's gang liaison and ensures gang prevention and intervention activities are provided to youth identified as gang members or affiliated with a gang. None of the seven reviewed youth case management records were applicable for youth with gang affiliations; therefore, the program's only two applicable youth records were reviewed. Both applicable youth received instruction in gang prevention and intervention strategies from the interim facility administrator using the Gang Resistance and Drug Education (GRADE) curriculum. Each youth's performance plan included relevant goals relating to gang intervention strategies.

The interim facility administrator interview revealed youth complete the Security Threat Group Questionnaire during admission, detailing any gang involvement and/or affiliation. The interview indicated the interim facility administrator is responsible to ensure the program shares pertinent gang-related information, as appropriate, with the Florida Department of Law Enforcement, local law enforcement, Department of Corrections, school districts, the judiciary, and social service agencies, as well as with a youth's juvenile probation officer (JPO) and, if identified, post-residential services counselor. The interview also reflected youth are educated on the negative consequences of gang membership and activity through monthly victim awareness groups, as well as social and life skills groups. For youth who are identified as gang members, the program

will conduct a special treatment team meeting to review the youth's behavior and determine most appropriate measure to address youth's involvement in gang related behavior, which will be included as a goal on the youth's Individual Performance Plan.

2.07 Residential Assessment for Youth (RAY) Assessments and Re-Assessments	Satisfactory Compliance
The program shall ensure an initial assessment of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS. The program shall ensure a reassessment of each youth is conducted within ninety days. The program shall ensure any other updates or reassessments are completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The program shall maintain all reassessment documentation in the youth's official youth case record.	

The program's policy and procedures state a Residential Assessment for Youth (RAY) will be completed on each youth within thirty days of admission and reassessments will be completed every ninety days. Seven youth case management records were reviewed, six of which were applicable for an initial RAY. The remaining youth record was for a youth admitted to the program prior to the annual compliance review period. Each of the applicable records contained a RAY assessment completed within thirty days of admission to the program. Each RAY assessment was appropriately maintained on the Department's Juvenile Justice Information System (JJIS) and a hard copy was contained in each record. All seven youth case management records were reviewed for RAY reassessments. All records contained documentation indicating RAY reassessments were completed within ninety days or less of the initial RAY assessment and within ninety days of each reassessment, as applicable. One youth required a reassessment based on special circumstances, which was completed. All reassessments were documented in Juvenile Justice Information System (JJIS) and each youth's case management record.

2.08 Youth Needs Assessment Summary (YNAS)	Satisfactory Compliance
The program shall ensure a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS on the YNAS.	

The program has a policy and procedures for the completion of a Youth Needs Assessment Summary (YNAS) one each youth within thirty days of admission. Seven youth case management records were reviewed, of which six were applicable. The remaining youth record was for a youth admitted to the program prior to the annual compliance review period. Five of the six applicable records documented a Youth Needs Assessment Summary (YNAS) completed within thirty days of admission to the program. In the remaining record, which was for a youth recommitted while in the program, the YNAS was started in the Department's Juvenile Justice Information System (JJIS) within thirty days of the recommitment date, and a needs assessment addendum completed within thirty days was in the record, but the actual completion date of the YNAS was twelve days late. Each YNAS was maintained in the youth's case management record and in JJIS.

2.09 Performance Plan Development, Goals and Transmittal (Critical)	Satisfactory Compliance
The intervention and treatment team, including the youth, shall meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission. *For each goal, the performance plan shall specify its target date for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal.* *Within ten working days of completion of the performance plan, the program shall send a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable.*	

The program has a policy and procedures regarding the development of performance plans. Seven case management records were reviewed for the development of performance plans, six of which were applicable. The remaining youth record was for a youth admitted to the program prior to the annual compliance review period. Each applicable record documented the youth's performance plan was developed within thirty days of admission to the program. Five of six performance plans were completed after the initial assessment with the treatment team leader, youth, administration representative, living unit representative, treatment staff, and education. In the remaining record, the initial assessment was started, and an addendum was documented prior to the completion of the performance plan; however, the assessment was completed in the Department's Juvenile Justice Information System (JJIS) after the completion of the performance plan.

All performance plans were entered into JJIS. Each performance plan included specific delinquency interventions and individualized goals. The performance plan goals contained target dates for completion and youth's responsibilities for each goal. Program staff responsibilities to enable the youth to complete the goals were documented for each goal in the performance plan with three exceptions. In these three records, there was one goal on the initial performance plan not including staff responsibilities. Subsequent updates/revisions to these three performance plans included staff responsibilities for each goal. Each of the goals identified on the performance plans were based upon the applicable youth's prioritized needs, reflecting the risks and protective factors identified during the initial assessment process and including the top three criminogenic needs, court-ordered sanctions, and education needs. Each performance plan had transition activities targeted for the last sixty days of the youth's anticipated stay. Each youth's recreation plan was included with their mental health/substance abuse treatment plan, as the recreation therapist reports to the clinical director. All seven interviewed youth reported participating in the development of their performance plans. All seven youth knew goals on their performance plan and received a copy of their performance plan.

There was documentation in each applicable record to support the program sent the performance plan to the committing judge, juvenile probation officer, and parent/guardian within ten working days of completion. All reviewed plans revealed signatures by the youth, treatment team leader, and all parties with significant responsibility in goal completion. One of the records contained a plan signed by the youth's parent/guardian. In the remaining records, there was documentation indicating a letter was sent to the parent/guardian requesting the parent/guardian review the performance plan, and sign and return the signature page.

2.10 Performance Plan Revisions	Satisfactory Compliance
Performance reviews shall result in revisions to the youth's performance plan when determined necessary by the intervention and treatment team.	

The program has a policy and procedures to address revisions to performance plans. A review of seven youth case management records determined the program completed, revised, and updated performance plans monthly during treatment team meetings. Performance plan revisions reflected youth demonstrating progress towards goals or goal completion. Revisions also addressed lack of progress towards goals, though there were four instances of target dates for goals pre-dating the revised plans. Performance plan revisions were made based on Residential Assessment for Youth (RAY) reassessment results and when new information about the youth was revealed, as warranted. One applicable active record and three closed records reviewed found performance plan revisions were made for facilitation of transition activities during the last sixty days of the youth's stay.

2.11 Performance Summaries and Transmittals	Satisfactory Compliance
The intervention and treatment team shall prepare a Performance Summary at ninety-day intervals, beginning ninety days from the signing of the youth's performance plan, or at shorter intervals when requested by the committing court. *Additionally, the intervention and treatment team shall prepare a performance summary prior to the youth's release, discharge, or transfer from the program.* *The program shall distribute the Performance Summary, as required, within ten working days of its signing.*	

The program has policies and procedures for the completion of performance summaries, performance summary transmittals, and release summaries. Seven active youth case management records were reviewed which included ten performance summaries. In each record, performance summaries included the youth's status on each goal, overall treatment progress, academic status, interactions with staff and peers, overall behavior adjustment to the program, level of motivation/readiness of change, interaction with peers and staff, and significant positive and negative events.

Each initial performance summary was completed within ninety days following the signing of the performance plan and three subsequent performance summaries were completed within ninety days of the previous performance summary. Each performance summary was signed and dated by the treatment team leader, the program director (PD) or designee, and the youth. Nine of the ten performance summaries contained documentation indicating the youth was permitted to read and add comments to their performance summary prior to signing. Documentation revealed all performance summaries were sent within ten working days of completion to the youth's assigned juvenile probation officer (JPO), parent/guardian, and the committing court. The original performance summaries were filed in individual youth case management records. Documentation showed each youth received a copy of their performance summary. All seven interviewed youth reported they were given a copy of their performance summary.

Three closed youth records were reviewed. Each closed record contained documentation demonstrating the original release summary was sent to the assigned JPO. Each release summary included a justification for the youth's release from the program and a signed copy of

the release summary was maintained in each youth's record. A Pre-Release Notification (PRN) was completed in accordance with require time frames, as applicable. Each record documented the program provided written notification to the youth's parent/guardian advising of the youth's anticipated release date once there was court approval for release.

Each closed record contained documentation indicating victim notification was completed at least ten days prior to release. Each closed record had a completed Residential Assessment for Youth (RAY) exit assessment and documented the transition plan was provided to the JPO. One youth was applicable for the Sexually Violent Predator Program (SVPP). For this youth, the program completed the JPO notification for release 240 days prior to the anticipated release date and included all required documents with the notification, to include the SVPP eligibility form/notification checklist, the youth's performance plan, a summary of the youth's adjustment to the program, and a physical health summary.

2.12 Parent/Guardian Involvement in Case Management Services	Satisfactory Compliance
The program shall, to the extent possible and reasonable, encourage and facilitate involvement of the youth's parent/guardian in the case management process.	

The program has a policy and procedures detailing how to encourage parent/guardian involvement in the case management process. A review of seven youth case management records found each contained documentation of the program's efforts to include each youth's parent/guardian in the case management process, including the initial assessment, development of the performance plan, progress reviews, and formal treatment teams. Documentation showed case management and treatment staff reached out to parents/guardians for input for the youth's needs assessment and performance plans. A letter including schedule treatment team meeting dates was found in each record reviewed. Treatment team documentation showed the program called parents/guardians to participate in the meetings, and parents/guardians often participated in treatment team meetings by phone. A review of three closed records found parents/guardians were also invited to attend the youth's transition conference, Community Re-Entry Team meeting, and exit staffing when placed in transition. Case management records also documented youth were given weekly telephone calls to contact parents/guardians and treatment records documented family counseling sessions. The program conducts quarterly family days, encouraging families to visit for a day of activities.

Six of the seven interviewed youth reported their parents/guardians are involved in the case management process, stating their parents/guardians participate in family therapy and treatment team meetings. The remaining youth answered: "No, my grandparents are not my guardians." The facility administrator interview indicted parents/guardian are contacted during the admission classification staffing, provided a copy of the treatment team calendar, and are included in the development of the youth's Individual Performance Plan.

2.13 Members of Treatment Team	Satisfactory Compliance
The team includes, at a minimum, the youth, representatives from the program's administration and residential living unit, education, and others responsible for providing or overseeing the provision of intervention and treatment services.	

The program has a policy and procedures identifying members of the treatment team and detailing treatment team participation. All seven reviewed youth case management records indicated treatment teams were composed of a treatment team leader, youth, administrative

representative, treatment staff, educational staff, medical staff, the youth's parent/guardian, the youth's assigned juvenile probation officer (JPO), and a representative from the youth's living unit. None of the reviewed records required Department of Children and Families (DCF) involvement. Documentation showed members of the treatment team from the program either attended treatment teams or provided written input for the treatment team meetings. Documentation also showed the program called parents/guardians and JPOs to participate in treatment team meetings.

2.14 Incorporation of Other Plans Into Performance Plans	Satisfactory Compliance
The youth's performance plan shall reference or incorporate the youth's treatment or care plan.	

The program has a policy and procedures for the incorporation of other plans (i.e., academic, medical, treatment plans) into the performance plan. Seven youth case management records were reviewed for incorporation of other plans into performance plans. Five of the seven initial performance plans incorporated all other plans into the performance plan. In one remaining record, the initial performance plan did not reference the youth's education or treatment plans; however, subsequent revisions to the youth's performance plan did incorporate the education and treatment plans, as well as a newly developed medical plan. In the second remaining record, the initial performance plan incorporated the youth's treatment plan, but not the education plan. Subsequent revisions to this youth's performance plan did incorporate the education plan. None of the records reviewed required Department of Children and Families (DCF) and or Agency for Persons with Disabilities (APD).

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include RAY reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment plan progress.	

The program has a policy and procedures for treatment team meetings. Seven youth case management records were reviewed. Each record contained documentation of bi-weekly treatment team meetings with alternating informal and formal treatment team meetings. Documentation of the formal and informal treatment team meetings included the youth's name, date of review, meeting attendees, treatment team member's comments, a brief synopsis of the youth's progress in the program, performance plan revision, progress on performance goals, positive and negative behaviors, behaviors resulting in physical intervention, treatment progress, and Residential Assessment for Youth (RAY) reassessment results, as applicable. A review of the Department's Juvenile Justice Information System (JJIS) showed the youth's anticipated release date was updated at least every ninety days. The informal treatment team meetings were conducted between the assigned case manager and youth and included written input from other members of the treatment team. For formal treatment team meetings, treatment team members from the program with either in attendance or provided written input for the meetings. In addition, there was documentation in each record to support the youth's juvenile probation officer (JPO) and parent/guardian were encouraged to participate and usually did participate in the formal treatment team meetings by telephone.

All seven interviewed youth reported treatment team meetings are conducted monthly. Five youth said staff review their performance to include progress on performance plan goals,

positive and negative behaviors, and treatment progress. Six youth stated they are given an opportunity during treatment team meetings to demonstrate any skills learned in the program.

2.16 Career Education	Satisfactory Compliance
Staff shall develop and implement a vocational competency development program.	

The program has a policy and procedures to provide for career education. Three closed youth case management records were reviewed. All three youth records included a sample completed employment application, a résumé, and information needed to obtain a State of Florida identification card. The three closed records contained information about each youth's local Career Source Center's location and hours of operation, which was included on the Youth's Plan for Success form. The Youth's Plan for Success form also contained pertinent information about resources and agencies in the youth's home area. The program provides a Type 3 vocational competency development program required for programs with a contracted length of stay of nine months or longer. Career education is provided by Volusia County Schools educational staff and, according to the interview with the lead teacher, all youth are enrolled in career and technical education classes and can earn certifications upon completion. The curriculum includes career technology education through the following courses: Digital Information Technologies; Digital Media Foundation; and Vocational Skills for Employment. The courses are all age appropriate and aligned with the youth's educational abilities and goals.

2.17 Educational Access	Satisfactory Compliance
The facility shall integrate educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way ensuring the integrity of required instructional time.	

The program has a policy and procedures to provide for educational access. The program integrates education into the daily schedule in such a way to ensure the integrity of the required minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and determined the program incorporated the required 250 days of instruction with ten days used for teacher planning. Youth are enrolled in academic courses through Volusia County Schools and receive credits when courses are completed. An interview with the lead educator indicated the school schedule is followed daily. In a review of the youth interviews, all seven youth indicated there are no interruptions during the school day. The logbook review confirmed the program is following the school schedule.

2.18 Education Transition Plan	Satisfactory Compliance
Upon admission, staff and youth develop an education transition plan which includes provisions for continuation of education and/or employment.	

The program has a written policy and procedures to provide for an educational transition plan. Three closed youth records were reviewed, and determined each record included the development of an education transition plan based on each youth's post-release goals. All required key personnel were included and the plan was developed with the youth, parents/guardians (if applicable, program, education, and aftercare staff involved. The plan placed specific monitoring responsibilities on individuals responsible for the reintegration and coordination of the provision of support services. Each record documented the youth's case manager and parent/guardian were aware of the plan. Seven youth were interviewed. When

asked how well they think the program is preparing them for a General Equivalency Diploma (GED), high school, vocational school, employment, and/or college, three answered very well and four answered well.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program, when developing each youth's performance plan and throughout its implementation during the youth's stay. *During the transition conference, participants shall review transition activities on the youth's performance plan, revise them if necessary, and identify additional activities/services as needed. Target completion dates and persons responsible for their completion shall be identified during the conference. The intervention and treatment team leader shall obtain conference attendees' dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth's performance plan.* *Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.*	

Three closed youth case management records were reviewed. Transition conferences were held within required time frames for each youth. Each record contained documentation demonstrating the youth, treatment team leader, facility administrator or designee, education staff, and other treatment team members participated in the transition conference. All records documented the juvenile probation officer (JPO) and parent/guardian were invited and encouraged to attend the transition conference. Each transition conference included a review of transition activities on the youth's performance plan and additional transition activities, to include targeted completion dates and persons responsible for completion. The transition conference documentation was signed and dated by all participants present for the transition conference. For those not in attendance, the transition conference information was emailed with a request for return signature. All records indicated the Community Re-entry Team (CRT) meeting was conducted prior to the youth's release with the case manager and youth participating.

2.20 Exit Portfolio	Satisfactory Compliance
The residential commitment program will assemble an exit portfolio for each youth to assist the youth once he/she is released back into the community.	

Three closed youth case management records were reviewed for exit portfolios. A copy of the exit portfolio was in each record. Each exit portfolio included a copy of the transition plan, calendar with all follow-up appointments, information for the community, birth certificate, vocational certificates, education records, school transcripts, résumé, and completed sample job applications. Two of the three exit portfolios included a copy of the youth's social security card and the remaining record documented the program requested a copy of the youth's social security card from the parent/guardian. One youth received a state identification card. One youth had the proper documents needed for the identification card, but due to the COVID-19 pandemic, was not able to obtain an identification card while at the program. For the remaining youth, it was noted the youth already had an identification card. All youth records included a Plan for Success listing post-release appointments and contact information for appointments needing to be scheduled upon release. Each exit portfolio also included the youth's educational

and vocational certificates and documents, school transcripts, a sample completed employment applications, and a résumé. The three closed records contained information about each youth's local Career Source Center's location and hours of operation, which was included on the Youth's Plan for Success form. The Youth's Plan for Success form also contained pertinent information about resources and agencies in the youth's home area. All three records indicated a copy of the exit portfolio information was forwarded to the juvenile probation officer.

2.21 Exit Conference	Satisfactory Compliance
An exit conference shall be conducted, in addition to a formal or informal meeting, to review the status of goals developed at the transition conference and finalize release plans.	

Three closed youth case management records were reviewed for exit conferences. Each record contained documentation demonstrating the exit conference was conducted at least fourteen days prior to the youth's release date and after the program notified the juvenile probation officer (JPO) of the release. The status transition activities were reviewed and updated during the exit conference, as needed. The exit conferences included the youth, treatment team leader, parent/guardian, JPO, education representative, and other pertinent staff. All exit conferences were separate from the transition and Community Re-Entry Team meetings. A review of the Department's Juvenile Justice Information System (JJIS) confirmed the date of admission and release correlated with admission and release dates documented in the closed records.

2.22 Safety Planning Process for Youth	Satisfactory Compliance
A residential program shall conduct an on-going safety planning process for each youth. The safety plan shall be designed to identify stimuli which have both positive and negative effects on the youth.	

The program maintains a safety plan for each youth. The safety plans are maintained in a binder in master control. Safety plans for seven youth were reviewed. Documentation showed the safety plans were jointly prepared by the youth, parent/guardian, and clinical staff. The safety plans were developed within fourteen days of the youth's admission and updated at least every thirty days during treatment team meetings. The plans included warning signs, baseline behaviors, crisis recognition, coping strategies, intervention strategies, and debriefing preferences, which are specific to each youth. All seven interviewed youth reported they contributed to their safety plan. Seven staff were interviewed. Six of the staff reported the safety plans are located in master control. The remaining staff thought the safety plans were in the clinical offices. All of the staff reported they are notified of information on the safety plans and they also review safety plans.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program. *Programs with an operating capacity of 100 or more youth, or those providing specialized treatment services, must have a single licensed mental health professional designated as the Designated Mental Health Clinician Authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services in the facility/program.* *Programs with an operating capacity of fewer than 100 youth or those not providing specialized treatment services, may have either a DMHCA or a Clinical Coordinator.*	

The program has a licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA). The DMHCA has a clear and active license in the State of Florida, which expires on March 31, 2021. The DMHCA is on-site forty hours each week Monday through Friday and is on-call and available twenty-four hours a day. An interview with the DMHCA revealed the DMHCA manages three full-time therapists and one pro re nata (PRN) therapist who provide clinical treatment services. The DMHCA is responsible for ensuring all services are provided, which includes juvenile sex offender groups, substance abuse prevention/education groups, weekly individual therapy, and monthly family therapy services. The DMCHA reported they conduct weekly clinical supervision meetings with the clinical team to discuss case reviews, documentation, medication management, and the program's positive performance system.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

In addition to the designated mental health clinician authority (DMHCA), the program has one licensed mental health counselor who obtained a license on April 14, 2020. The licensed therapist has a clear and active license in the State of Florida, expiring March 31, 2021. A review of documentation confirmed the licensed therapist was on-site Monday through Friday, as well as, one Sunday every three weeks. A review of the DMHCA's training reflected all requirements under Rule 64B4-7.007 to practice juvenile sexual offender therapy were completed.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program has three non-licensed mental health and substance abuse clinical staff. Each non-licensed clinical staff obtained a master's degree with specializations in psychology, counseling, and human relations. Two non-licensed therapists work full-time, and one therapist is working as needed (pro re nata) who is still receiving on-the-job training according to an interview the designated mental health clinician authority (DMHCA). One of the non-licensed therapists has completed twenty hours of training and supervised experience to conduct Assessments of Suicide Risk (ASR). The training included five supervised ASRs and the training was completed on December 10, 2018. One non-licensed therapist has started ASR training and completed two of the five required ASRs under the supervision of the DMHCA. A review of clinical supervision logs for the past six months found the non-licensed clinical staff received at least one hour of clinical supervision each week by the DMHCA. The direct clinical supervision was documented on a program form similar to the Department Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form (MHSA 019), which included the required components documenting the date, time, duration, and to include the five sections of case load review, clinical services, documentation, miscellaneous, and the Standardized Program Evaluation Protocol (SPEP). The program has the required Chapter 397 licensure to provide outpatient substance abuse treatment services. The effective date of the license was April 8, 2020 and the license expires on April 7, 2021.

3.04 Mental Health and Substance Abuse Admission Screening	Satisfactory Compliance
The mental health and substance abuse needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.	

The program has a policy and procedures regarding a standardized screening process for mental health and substance abuse through the administration of the Massachusetts Youth Screening Instrument (MAYSI-2), Assessment of Suicide Risk (ASR), Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Adolescent Substance Abuse Subtle Screening Inventory (SASSI), Beck's Depression Inventory (BDI-2), State Trait Anger Expression Inventory (STAXI-2), and Reynolds Children's Manifest Anxiety Scale (RCMAS-2). The program's policy also indicates all youth are referred for a Comprehensive Bio-Psychosocial Evaluation.

Seven youth mental health and substance abuse treatment records were reviewed for mental health and substance abuse admission screenings. Each record contained a MAYSI-2 completed on the youth's date of admission and was entered into the Department's Juvenile Justice Information System (JJIS). Each MAYSI-2 was completed by staff trained to conduct the MAYSI-2. Five of the seven assessments were completed in full. The remaining two assessments did not notate a service response; however, all youth were referred for further evaluation. Based on the MAYSI-2 results, five of the seven youth reviewed were identified in need of further assessment in the areas of angry-irritable, depressed-anxious, somatic complaints, thought disturbance, or traumatic experiences. One assessment reflected the youth

needed further revaluation in the area of suicide ideation. Each youth was referred utilizing a Mental Health Services Referral and MAYSI-2 Referral Form to be seen by the psychiatrist for an evaluation. By policy, each youth receives an ASR, a comprehensive evaluation, and psychiatric referral. Each record documented each youth received an ASR on the youth's date of admission. Each record contained a records review form which documented a review of the comprehensive evaluation, face sheet, commitment packet, and completed assessments. An interview with the facility administrator confirmed the youth are screened during utilizing the MAYSI-2 and ASR.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory Compliance
Youth identified by screening, staff observation, or behavior after admission as in need of further evaluation must be referred for a Comprehensive Mental Health Evaluation and/or Comprehensive Substance Abuse Evaluation or Updated Evaluation.	

The program has a policy and procedures in place indicating all admitted youth are referred for a Comprehensive Bio-Psychosocial Evaluation which incorporates a psychosexual evaluation. Seven mental health and substance abuse treatment records were reviewed for mental health and substance abuse assessments and evaluations. Each youth received a new comprehensive bio-psychosocial evaluation within thirty calendar days of admission. Each evaluation was signed by the clinical staff completing the evaluation and the designated mental health clinical authority (DMHCA) within ten calendar days of the evaluation completion. Each evaluation contained identifying information, the reason for the evaluation, relevant background information, behavioral observations, a mental status examination, and the interview or procedures administered. Each evaluation contained a discussion of the findings, the diagnostic impressions, and recommendations. Each evaluation contained substance abuse information including patterns of alcohol and other drug abuse, the impact of alcohol and other drug use on the major life areas, risk factors of continued alcohol or drug abuse, and strength/resiliency factors. Each record contained a signed consent for substance abuse services and release of records. The program has the required Chapter 397 licensure to provide outpatient substance abuse treatment services. The effective date of the license was April 8, 2020 and the license expires on April 7, 2021.

3.06 Mental Health and Substance Abuse Treatment	Limited Compliance
Mental health and substance abuse treatment planning in Departmental facilities focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. *The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.*	

The program has a policy and procedures addressing mental health and substance abuse treatment and discharge planning. Seven mental health and substance abuse treatment records were reviewed for mental health and substance abuse treatment. Each record confirmed the youth are assigned to a treatment team meeting upon arrival to the program. Treatment team documentation for each youth confirmed representatives from administration, medical, mental health/substance abuse clinical staff, and the parent/guardian, if available, participated in treatment team. Each record documented the youth received substance abuse treatment in accordance with the initial and individualized treatment plan. Each record contained a properly

executed Authority for Evaluation of Treatment (AET). Each record contained a signed Substance Abuse Consent and Release form and Youth Consent for Release of Substance Abuse Treatment Records.

The treatment progress notes were documented on a program form which contained all required information on the Department's form. Treatment progress notes and group sign-in sheets confirmed mental health groups were limited to ten or fewer youth and substance abuse groups were limited to fifteen or fewer youth, as required. Therapists who provide substance abuse education are qualified to provide the services.

Each record contained progress notes documenting individual and group treatment services were received, as stipulated by the youth's treatment plans. Three of the seven reviewed records documented the youth received monthly family counseling sessions. One record did not contain documentation of family counseling for three months, one youth was missing two months of family counseling, one youth was missing two months of family counseling, and one youth was missing one month of family counseling. An interview with the DMHCA indicated the program had two non-licensed therapists resign with only a three-day notice; therefore, some family counseling sessions were missed as there was only one therapist and the DMHCA on staff at the time. It was documented on February 26, 2020 a therapist from another program submitted a bid form to transfer as soon as a therapist was found to fill the Hastings position. The therapist was to report to Daytona JRF on Mondays to assist with individual counseling. The therapist was to officially transfer on April 6, 2020.

Seven interviewed youth reported participation in weekly individual counseling and monthly family counseling with one youth reporting they have been unable to reach their parent/guardian. Seven interviewed direct-care staff reported they do not provide mental health and substance abuse treatment groups with one staff reporting they facilitate Impact of Crime (IOC). An interview with the designated mental health clinical authority (DMHCA) indicated the program provides sex offender therapy, recreational therapy, and weekly substance abuse prevention/education groups. The DMHCA reported the recreational therapist facilitates indoor and outdoor activities with the youth.

3.07 Treatment and Discharge Planning (Critical)	**Satisfactory Compliance**
Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed. *All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

Seven youth mental health and substance abuse treatment records were reviewed for treatment and discharge planning. Each record contained an initial treatment plan developed on the date of the youth's admission, which was also the start date of the youth's treatment. Each initial mental health/substance abuse treatment plan was completed on a program form which contained the required elements included on the Department's form. Each plan was signed by the mental health clinical staff completing the form, as well as, the treatment team members

who participated in the development of the plan, and the licensed mental health clinical supervisor within ten days of the plan's completion. Two of the initial treatment plans were completed by the designated mental health clinical authority (DMHCA). Five of the seven initial treatment plans documented the plan was reviewed with the parent/guardian, and one documented an attempted contact with the parent/guardian. Each initial treatment plan documented the youth's psychiatric needs to include medication, or a referral to the psychiatrist.

Each youth mental health and substance abuse treatment record contained an individualized treatment plan developed within thirty days of the youth's admission, and initiation of treatment. Each individualized treatment plan was completed on a form with all required elements of the Department's form. Each plan was signed by the youth, case manager, treatment team members, mental health/substance abuse clinical staff, and the licensed clinical supervisor within ten days of the plan's completion, with three individualized treatment plans completed by the DMHCA. One record contained a plan which was returned as signed by the youth's parent/guardian. At the time of the individualized treatment plan, three of the seven youth were prescribed psychotropic medication and the youth's record included the psychotropic medication and frequency of monitoring by the psychiatrist. Each individualized treatment plan was completed on a program form which contained of the required elements of the Department's form and prescribed services for the youth to include weekly individual therapy, daily group therapy, and monthly family counseling. Each record documented individualized treatment plan reviews were conducted at a minimum of every thirty days following the development of the individualized treatment plan.

Three closed mental health and substance abuse treatment records were reviewed for discharge planning. Each record contained a mental health/substance abuse discharge plan documented on the Department's Treatment Discharge Summary form. None of the records indicated the youth was applicable for notification of suicide risk/precautions at the time of discharge. Each discharge summary identified services needed for daily maintenance of the youth's skills learned during treatment. Each record documented the discharge plan was discussed with the youth, parent/guardian, and the juvenile probation officer (JPO) during the exit conference. Each closed record documented a copy of the mental health/substance abuse discharge summary was provided to the youth, and parent/guardian upon release. Two of three closed records documented a copy of the discharge summary was provided to the juvenile probation officer.

3.08 Specialized Treatment Services (Critical)	**Satisfactory Compliance**
Specialized treatment services shall be provided in programs designated as "Specialized Treatment Services Programs" or are designated to provide "Specialized Treatment Overlay Services.".	

The program has a bed capacity of thirty-three male youth and provides juvenile sex offender treatment planning and therapy. Treatment progress notes confirmed the program provides sex offender treatment services, substance abuse treatment, and group treatment is provided on a daily basis. The clinical staff provide juvenile sex offender groups three days a week, substance abuse groups two days a week, and mental health groups two days a week. The program also provides weekly individual counseling, monthly family therapy, crisis intervention, and therapeutic activities. The program contracts with a psychiatrist who is board certified in child and adolescent psychiatry who is on-site bi-weekly to conduct psychiatric evaluations, provides medication management, and participate in treatment planning. The designated mental health clinical authority (DMHCA) and an additional licensed mental health professional are on-site five

days a week for a total of forty hours each. Mental health staff rotate weekends and are on-site seven days a week to provide daily group clinical services. A review of the DMHCA's training reflected completion of training requirements under Rule 64B4-7.007 to practice juvenile sexual offender therapy. An interview with the facility administrator confirmed the program provides specialized sex offender treatment services.

During the month of February 2020, the program had two non-licensed clinical therapists resign with a three-day notice and the youth to counselor ratio became 1:16 and 1:17. A therapist with the provider from a neighboring program assisted at the program and was eventually transferred to this program full-time. It was documented on February 26, 2020 a therapist from another program submitted a bid form to transfer as soon as a therapist was found to fill the Hastings position. The therapist was to report to Daytona JRF on Mondays to assist with individual counseling. The therapist was to officially transfer on April 6, 2020. The mental health department is currently fully staffed and the counselor to youth ratio does not exceed 1:10.

3.09 Psychiatric Services (Critical)	**Satisfactory Compliance**
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C. ****Tele-psychiatry is not currently approved for use in Residential Programs****	

The program contracts with a psychiatrist who is board-certified in child and adolescent psychiatry. The psychiatrist has a clear and active license in the State of Florida with an expiration date of January 31, 2022. The psychiatrist is on-site biweekly for at least eight hours each site visit. The psychiatrist is available for emergency consultation twenty-four hours a day, seven days a week. Sign-in sheets reviewed for the last six months confirmed the psychiatrist has been on-site at least eight hours on a bi-weekly basis. The psychiatrist conducts psychiatric evaluations, provides medication management, and meets with the program bi-weekly during the management meeting to provide the medical and mental health staff with medication management updates and update the treatment team.

A review of seven youth mental health and substance abuse treatment records reflected each youth was referred for a psychiatric evaluation. Three youth entered the program on psychotropic medications and were assessed by the psychiatrist within fourteen days of admission. The remaining three youth were referred for an evaluation and were assessed by the psychiatrist within thirty days of the referral. Each psychiatric evaluation was a new assessment which included the youth's medical, mental health and substance abuse history, a mental status examination, diagnosis, and treatment recommendations. Three of seven youth were applicable for entering the program on psychotropic medication and the remaining four youth were prescribed psychotropic medication subsequent to admission. Each psychiatric evaluation included the prescribed medication, the diagnosis, target symptoms, potential side effects, risk and benefits of taking the medication, and the frequency of medication monitoring on the Clinical Psychotropic Progress Note (CPPN). Each record reflected medication management was conducted with the psychiatrist at a minimum of every thirty days.

A interview with the psychiatrist indicated the psychiatrist is routinely on-site once every two weeks, but if there is a clinical concern which needs to be addressed between these routine on-site visits, the psychiatrist is available to be on-site more frequently. The psychiatrist confirmed

every youth who is admitted into the program receives an initial psychiatric evaluation, and based on the evaluation, a determination is made regarding psychiatric follow-up. The psychiatrist indicated youth who are assessed as not needing psychotropic medications may be placed on as needed follow-up and can be re-assessed based upon the urgency and availability. The youth who are prescribed medications are to be seen at least once every thirty days. The psychiatrist confirmed meeting with the treatment team face-to-face every two weeks for a multidisciplinary psychiatry meeting to coordinate and implement services with input from therapy providers, case management, nurses, and operations leadership.

3.10 Suicide Prevention Plan (Critical)	Satisfactory Compliance
The program follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with the Rule 63N-1, Florida Administrative Code.	

The program has a policy and procedures addressing a suicide prevention plan which was signed by the facility administrator and designated mental health clinician authority (DMHCA) on June 26, 2020. The suicide prevention plan includes the identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, and the referral process. The plan also includes the steps for communication, notification, documentation, immediate staff response, a review process for suicide attempts, and a mortality review process. An interview with the facility administrator indicated the program conducts drills on a month basis.

3.11 Suicide Prevention Services (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. *Any youth exhibiting suicide risk behaviors shall be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.* *All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations shall be placed on Suicide Precautions and receive an Assessment of Suicide Risk.*	

Seven youth mental health and substance abuse treatment records were reviewed for suicide prevention services. Two of the seven records reviewed were applicable for a youth placed on precautionary observation with a total of five incidents between the two youth. Two incidents were during admission screening and the remaining three incidents were due to self-report. In each instance, the youth were placed on precautionary observation and were referred for an Assessment of Suicide Risk (ASR). Each ASR was completed on the date of the referral or within twenty-four hours of being placed on precautionary observation and referred for an ASR. Mental health staff provide supportive services and precautionary observation was authorized.

The initial ASR in two instances determined the youth was no longer a suicide risk and the youth were placed on close supervision. Two initial ASRs determined the youth were to remain on constant supervision. Each record contained a Follow-up ASR placing the youth on close supervision. In the remaining record, the youth was on precautions prior to the ASR and was transitioned directly to standard precautions. In each instance, an ASR was completed prior to

the removal from precautionary observation and a conference was held with the program director and licensed mental health professional prior to the reduction in the level of supervision.

Each ASR documented the date and time the staff conferred with the licensed mental health professional and program director. Each ASR was signed by the mental health clinical staff completing the ASR, the licensed mental health staff, and program administrator. Two of the five ASRs documented contact was made with the parent/guardian and juvenile probation officer (JPO) to notify of the youth's potential suicide risk as indicated by the ASR. A review of the Department's Juvenile Justice Information System (JJIS) reflected suicide alerts were entered when the youth were identified as being a suicide risk. Three of the five alerts were closed timely when the youth was removed from suicide precautions. One alert was updated sixty days after the youth was removed from precautionary observation and one alert was updated seventy-six days after the youth was removed from precautionary observation. Precautionary observation did not limit the youth to sleeping rooms and the youth participated in select activities with other youth in designated safe housing areas of the program.

Each ASR was completed by a licensed mental health clinician or a non-licensed mental health clinician who completed twenty hours of required training by a licensed professional to include five supervised ASRs. Each ASR was signed by the licensed mental health professional. The program does not utilize secure observation. Each applicable record contained a suicide precaution observation log. The facility logbook contains a section to notate any youth on suicide precautions. The logbook documented youth identified were on suicide precautions; however, did not document removal of precautionary observation in three instances. Each mental health record documented the discontinuation of suicide precautions and step down to close supervision.

The program maintains two suicide response kits which includes the Knife for Life, wire cutters, and needle nose pliers in master control and administration. The program maintains an alert board in administration for staff to pass on information related to suicide precautions.
The program has a policy and procedures which includes a review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The plan was signed by the designated mental health clinical authority (DMHCA) and the facility administrator on June 26, 2020. The multidisciplinary review includes the circumstances surrounding the event, facility procedures relevant to the incident, all relevant trained received by involved staff, pertinent medical and mental health services involving the victim, and the possible precipitating factors. The policy addresses recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Seven interviewed staff reported if a youth expresses suicidal thoughts, staff are responsible for notifying mental health staff, and documenting supervision. In addition, five staff reported the youth is placed on constant sight and sound, and one staff reported staff search the youth's room for sharps. In addition, one staff reported they would call a code, and four staff reported staff would notify the supervisor. Two staff reported staff would also notify the medical department and the assistant facility administrator. Each staff reported the suicide response kit is maintained in master control and four staff identified the location of the second suicide respond kit in administration.

3.12 Suicide Precaution Observation Logs (Critical)	Satisfactory Compliance
Youth placed on suicide precautions shall be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth shall provide the appropriate level of supervision and record observations of the youth's behavior at intervals of thirty minutes, at a minimum.	

Two youth mental health and substance abuse treatment records reviewed were applicable for youth on suicide precautions with a total of four precautionary observation instances applicable for requiring a suicide precaution observation log. Each suicide precaution observation log was maintained for the duration the youth was on suicide precautions and observations documented did not exceed thirty-minute intervals. None of the precautionary observation logs reviewed documented any warning signs were displaying by the youth while on precautionary observation. Three of the four records documented precautionary observation logs were signed by the shift supervisor, with one log not signed by the shift supervisor. Each log was signed by a mental health clinical staff. The suicide precaution observation logs documented safe housing requirements. Two youth who were placed on precautionary observation were interviewed and each reported while on suicide precautions they were with staff at all times and were not left alone for any period of time.

3.13 Suicide Prevention Training (Critical)	Limited Compliance
All staff who work with youth shall be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.	

A review of seven pre-service and seven in-service staff training records reflected each staff completed at least six hours of suicide prevention training to include two hours of training in the Department's Learning Management System (Skill Pro), and four hours of instructor-led training.

Documentation reflected the program conducted suicide drills at least once each quarter on each of the three shifts, with drills conducted monthly during one of the three shifts. A review of the drills compared to the staff roster reflected twenty-four of twenty-eight applicable staff participated in at least one quarterly suicide drill semi-annually. Documentation reflected at fifteen of twenty-eight reviewed direct-care staff participated in a drill which included the use of cardiopulmonary resuscitation (CPR) annually. Twenty-four of the twenty-eight staff participated in quarterly drills. The suicide drills documented a description of the incident, a synopsis of the response, deficiencies identified, and corrective action, if applicable. The program staff who are not present are able to review each drill scenario and procedures.

Five of seven interviewed staff reported medical emergency and suicide drills are conducted monthly on their shift. One staff reported drills are conducted weekly, and the remaining staff reported they participated in a drill the week prior.

3.14 Mental Health Crisis Intervention Services (Critical)	Satisfactory Compliance
Every program shall respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others, while maintaining control and safety of the facility. The program shall be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others which would require suicide precautions or emergency treatment.	

The program has a policy and procedures addressing the program's crisis intervention plan, which is separate from the program's emergency mental health and substance abuse plan. The plan was signed by the designated mental health clinician authority (DMHCA) on July 2, 2020, and the facility administrator on June 26, 2020. According to the plan, the goal of crisis intervention at the program is to respond to youth in crisis in the least restrictive method possible, and to protect the personal safety of the youth and others while maintaining control and safety of the program. The crisis intervention plan addresses a notification and alert system, means of referral, including a youth self-referral, communication, and supervision to include one-to-one, close, and standard supervision. The plan also includes procedures for documentation and review.

3.15 Crisis Assessments (Critical)	Limited Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the program director or designee shall be notified of the crisis situation and need for crisis assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment.	

The program conducted one Crisis Assessment during the annual compliance review period. The Crisis Assessment was conducted on the date the youth was determined to be in crisis. The assessment included the youth's identifying information, the reason for the assessment, a mental status examination, a determination of danger the youth presents to themselves or others to include the imminence of behavior, intent of behavior, clarity of danger, and lethality of behavior. The Crisis Assessment also included the initial clinical impression, supervision recommendations, treatment recommendations, and recommendations for follow-up or further evaluation. The assessment documented the parent/guardian was notified. The assessment was completed by a non-licensed mental health clinical working under the direct supervision of a licensed mental health professional. A review of the Department's Juvenile Justice Information System (JJIS) did not reflect a mental health alert was entered after the completion of the Crisis Assessment. It is noted the program contacted the Volusia County Sheriff's Office due to the incident and the youth was taken into custody on the date of the incident. The Crisis Assessment was signed by the licensed mental health staff seven days after the incident, thus making it six days late. A mental health alert observation log was started when it was determined the youth was in crisis. Upon the youth's return to the program, documentation was not provided reflecting the youth was on constant supervision. A mental status exam was

completed on the date of the youth's return to the program. Documentation reflected the youth was recommended to step down to close supervision; however, documentation did not reflect the youth was stepped down from close supervision to standard supervision. The program acknowledged a follow-up mental status exam was not conducted to step the youth down to standard supervision and staff were only verbally informed the youth's supervision level was being reduced to standard supervision. The program implemented corrective action immediately following this incident.

3.16 Emergency Mental Health and Substance Abuse Services (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health and substance abuse emergencies occurring in facility require emergency care provided in accordance with Rule 63N-1 Florida Administrative Code and the facility's emergency care plan.	

The program has a policy and procedures in place addressing an emergency mental health and substance abuse plan, which is separate from the program's crisis intervention plan. The plan was signed by the assistant facility administrator on June 26, 2020. The plan includes the immediate staff response, notifications, communication, supervision, and authorization to transport for emergency mental health or substance abuse services. The plan also includes transportation for an emergency mental health evaluation and treatment under Chapter 394 for a Baker Act, and transportation for an emergency substance abuse assessment and treatment under Chapter 397 for a Marchman Act. The plan also includes procedures for documentation, training, and a review process. The plan identified the receiving facility for a Baker Act, which is Halifax Behavioral Services in Daytona Beach, Florida and the receiving facility for a Marchman act, which is Halifax Hospital.

3.17 Baker and Marchman Acts (Critical)	Non-Applicable
Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.	

The program did not utilize a Baker Act or Marchman Act procedure during this annual compliance review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

4.01 Designated Health Authority/Designee (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) shall be clinically responsible for the medical care of all youth at the facility.	

The designated health authority (DHA) is a licensed physician who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida with specialty training in family practice. The DHA holds a clear and active license in the State of Florida which expires on March 31, 2022. The alternate physician specializes in internal medicine and has a license which expires on January 31, 2022, and liability insurance expiration of June 27, 2021. The DHA has an agreement with an alternate physician to cover any scheduled absences. The DHA was on-site weekly for two hours on Wednesdays to provide medical care and clinic oversight. This schedule was verified through review of the DHA sign-in logs for the past six months. The DHA is responsible for communication with the program staff regarding youth medical needs and is on call twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care.

An interview with the DHA revealed, as the primary physician, the DHA sees all youth upon admission for a full Comprehensive Physical Assessment (CPA) and then yearly. The DHA conducts periodic evaluations every sixty-days for chronic clinic youth, completes sick call and psych referrals, recommends the need for off-site referrals to specialty physicians, confer with staff regarding updated policies and procedures, and ensures staff adhere to further advances in policy recommended changes.

4.02 Facility Operating Procedures	Satisfactory Compliance
The program shall have Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.	

The designated health authority (DHA) and facility administrator (FA) documented an annual review of all written facility operating procedures (FOP) and treatment protocols, as indicated by a dated signature on June 16, 2020. Approval of treatment protocols were developed and authorized by the DHA. Nursing staff members signed and dated a cover page indicating a review of the treatment protocols on June 20, 2020. All FOPs and protocols related to psychiatric services were reviewed and approved by the program's contracted psychiatrist on June 16, 2020.

4.03 Authority for Evaluation and Treatment	Satisfactory Compliance
Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department.	

All seven reviewed individual healthcare records contained a valid copy of the Authority for Evaluation and Treatment (AET) form. The forms were all legible, stamped "copy," and signed by the parent/guardian and a Department representative. Parental notifications were filed behind the AET in all seven records. Two of the youth entered the program at eighteen years of age, their records contained a completed release of information form. An interview with the nurse confirmed medical staff review the Department's Juvenile Justice Information System

(JJIS) prior to the youth's admission, and if an AET is not received, staff contact the case manager who then contacts the juvenile probation officer (JPO) to locate or initiate.

4.04 Parental Notification/Consent	Satisfactory Compliance
The program shall inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed.	

Seven youth individual healthcare records were reviewed, of which five were applicable for parental notifications. The remaining two of the youth were eighteen years of age upon admission at the program. The notifications included the use of over-the-counter medications beyond those covered in the Authority for Evaluation and Treatment (AET), vaccinations/immunizations, changes in medication, discontinuation of medication, and non-routine dental procedures. The progress notes reflected the signature of the staff who witnessed the telephone call when consent was obtained by telephone. Two youth were receiving psychotropic medication upon arrival and five youth began psychotropics after admission, of those, two were eighteen years of age upon entering the program. Documentation reflected notification was mailed along with the Clinical Psychotropic Progress Note (CPPN) and explanatory information when the youth was seen by the psychiatrist. Immunizations were verified for all seven youth within thirty days of the youth admission. Each youth's admission progress note confirmed the youth's immunization history was reviewed upon admission and the nursing interview confirmed the review is completed through the Florida SHOTS website and/or by obtaining school records.

4.05 Healthcare Admission Screening and Rescreening Form (Facility Entry Physical Health Screening Form)	Satisfactory Compliance
Youth are screened upon admission for healthcare concerns which may need a referral for further assessment by healthcare staff.	

Seven youth individual healthcare records were reviewed, and revealed each contained a Facility Entry Physical Health Screening (FEPHS) form. Each of the forms were completed by a registered nurse (RN) or a licensed practical nurse (LPN) on the day of the youth's admission. One youth had a change in physical custody and a new FEPHS form was completed for the youth upon their return.

4.06 Youth Orientation to Healthcare Services/Health Education	Satisfactory Compliance
All youth shall be oriented to the general process of health care delivery services at the facility.	

Seven youth individual healthcare records were reviewed, and each reflected the youth received a general care orientation upon admission to the program. The topics reviewed included access to medical care, sick call, what constitutes an emergency, medication process to include side effect monitoring, the right to refuse care, sexual assault, and the non-disciplinary role of the healthcare providers. The list of health care contacts was reviewed and confirmed to be accurate.

4.07 Designated Health Authority (DHA)/Designee Admission Notification	Satisfactory Compliance
A referral to the facility's Physician, PA, or ARNP shall be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission.	

Seven youth individual healthcare records were reviewed. Each record documented the designated health authority (DHA) was notified of the youth's admission. The DHA was notified by telephone at the time of each youth's admission which was documented on each intake admission in the individual healthcare record.

4.08 Health-Related History	Satisfactory Compliance
The standard Department Health-Related History (HRH) form shall be used for all youth admitted into the physical custody of a DJJ facility.	

Seven youth individual healthcare records were reviewed for completion of a Health-Related History (HRH) form. In each youth's record, the HRH was completed on the day of the youth's admission. All seven reviewed records documented the designated health authority (DHA) reviewed the HRH by a check box on the Comprehensive Physical Assessment (CPA). An interview with the nurse revealed a HRH is completed within seven days of admission, and every year thereafter, and if there is any significant change in youth's condition from what is documented on the original CPA.

4.09 Comprehensive Physical Assessment/TB Screening	Satisfactory Compliance
The standardized Comprehensive Physical Assessment form shall be used for all youth admitted into the physical custody of a DJJ facility.	

Seven youth individual healthcare records were reviewed for completion of the Comprehensive Physical Assessment (CPA) form. The program uses the Department's Comprehensive Physical Assessment (CPA) form. The nurse indicated the designated health authority (DHA) completed a new CPA on all admissions within seven days of admission and on a yearly basis for all youth. Each of the seven records had a CPA which was completed by the DHA within seven calendar days of the youth's admission. All seven youth were identified as medical grade five. Each of the CPAs were completed in accordance with 63M-2.0048. The CPAs were fully completed "youth refused" written by the DHA for any part the youth refused. All of the youth signed the CPA. The Department's Problem List was updated, as required. All seven youth records contained a verified tuberculin skin test (TST) which was documented on the youth's CPA and Infectious and Communicable Disease (ICD) forms. All seven youth were assessed prior to placement in the general population.

An interview with the nurse revealed nursing staff provides the youth with a TST within seven days of admission if they have one of the symptoms listed in the policy or if there is no documentation one has been given to the youth within twelve months. Staff receive test results within forty-eight to seventy-two hours and document all within the Tuberculosis Testing Log and in the IHCR.

4.10 Sexually Transmitted Infection/HIV Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if indicated) for sexually transmitted infections (STIs) and HIV risk factors.	

A review of seven youth individual healthcare records (IHCR) determined each youth was screened for sexually transmitted infections (STIs) on the date of admission. The testing was ordered and completed on the date of admission in all seven IHCRs. All seven youth records contained testing documentation and when applicable, diagnosis documented on Infectious and Communicable Disease (ICD) forms and filed in the lab section of the IHCRs. Five of the seven youth records documented the youth were each offered counseling, testing, and treatment, if needed, for Human Immunodeficiency Virus (HIV). The remaining two youth were over the age of eighteen and refused testing. Documentation in the five IHCRs included pre/posttest counseling provided by Community Outreach. HIV results were filed confidentially in a sealed envelope marked “CONFIDENTIAL.” Six of the seven interviewed youth advised they could ask for HIV testing.

4.11 Sick Call Process	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system. The program shall respond appropriately, in a timely manner, and document all sick call encounters as required by the Department. All youth in room restriction/controlled observation shall have timely access to medical care, as required by Rule.	

Three of the seven reviewed records were applicable for a sick call request. One of the three youth presented with a similar sick call complaint twice within a two-week period and was seen by the designated health authority (DHA) on February 12, 2020 and February 26, 2020. None of three youth required a referral or were required to be treated as an emergency. Each youth completed a Sick Call Request form and placed it in the sick call box. The nurse completed the sick call request form and filed the form in the youth individual healthcare record. Documentation included the youth’s vital signs, treatment, education, and follow-up plans. Sick calls were documented on the sick call index and the sick call referral log. Sick call is conducted in the clinic treatment room by a registered nurse daily between 1:00 p.m. and 2:00 p.m. The hours for sick call are posted in medical, education, administration, and on each dormitory. Sick call was unable to be observed during the annual review, as none of the youth submitted a Sick Call Request during the annual compliance review. All seven interviewed staff indicated the nurse or medical staff responds and conducts sick call. Six of the seven interviewed youth reported youth are seen within one day, and one youth advised he has never made a sick call request.

4.12 Episodic/First Aid and Emergency Care	Satisfactory Compliance
The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.	

The program has a policy and procedures for episodic and emergency care which include emergency medical and dental care are available twenty-four hours a day. Program staff can call 9-1-1 for emergency medical services. A review of seven youth individual healthcare records reflected one youth received on-site first aid or episodic care. Two additional records were reviewed for episodic and emergency care. Each of the three instances documented the nature of the complaint, day and time of episodic care, and problem-oriented charting by the

licensed healthcare staff. First aid kits are located in kitchen one, kitchen two, classroom B, administration, escape bag, transport one, transport two, transport three, medical, and master control. The first aid kits are checked every Sunday by the nurse. A review of the first aid kits documented the nurse initialed and dated on the back of the first aid kit, as required. The program has two suicide response kits, one in master control and on in administration. The program has one automated external defibrillator (AED) located in master control along with the procedures for the device. A nurse checks the AED monthly to ensure the battery and pads are operable. The batteries expire July 4, 2022 and were last change July 14, 2018. The AED pads expire October 20, 2020 and were last changed October 3, 2019. Documentation reflected emergency drills were held monthly on each shift and included the use of AED and cardiopulmonary resuscitation. Emergency numbers, including Poison Information Control Center, are posted in master control, medical, and the facility administrator's office.

A review of staff training records reflected staff were trained in the use of an epinephrine auto injector. Nurses and staff training records reflected they have current CPR, first aid, and AED training. All seven interviewed staff stated they could call 9-1-1 in the event of a medical emergency. Each of the seven interviewed youth stated they could see a doctor, if needed.

4.13 Off-Site Care/Referrals	Satisfactory Compliance
The facility shall provide for timely referrals and coordination of medical services to an off-site health care provider (emergent and non-emergent), and document such services as required by the Department.	

None of the seven individual healthcare records (IHCR) reviewed were applicable for off-site care; therefore, three additional applicable records were reviewed. Two of the three IHCRs contained parental notifications, and the remaining IHCR was for a youth who was eighteen years old and did not require parental notification. In all three records, the Summary of Off-Site Care form was used and filed in the youth's record along with discharge and other related documents. The designated health authority reviewed and signed all off-site care findings, instructions, and information. None of the three youth required follow-up testing, referrals, or appointments.

4.14 Chronic Conditions/Periodic Evaluations	Satisfactory Compliance
The facility shall ensure youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up.	

The program has a policy and procedures regarding the evaluation and treatment of chronic conditions which requires frequent follow-ups at least every two months and monthly medication management. Seven youth individual healthcare records (IHCR) were reviewed and seven were applicable of youth taking psychotropic medications. Each of the seven youth received an evaluation every month which was maintained in the youth's IHCR. There were no lapses in care. Periodic evaluations were conducted prior to prescribing medication. The designated health authority (DHA) confirmed periodic evaluation are completed every sixty days or more often, as needed. The DHA further indicated nurses maintain a chronic log and youth are scheduled by the nurses every sixty days or less. The DHA indicated adhering to the strict sixty-day tracker kept by the medical department which is updated and overseen by the DHA.

4.15 Medication Management	Satisfactory Compliance
Medication shall be received, stored, inventoried, and provided in a safe and effective manner which shall be demonstrated by observation, review of documentation of procedures and processes.	

Three of the seven reviewed individual healthcare records (IHCR) were applicable for youth admitted to the program with prescribed medication. In all three applicable records, the youth's medication status was documented on the admission progress note. In each record, the designated health authority (DHA) was notified of the youth's admission and ordered the medication to continue as prescribed. All of the medications had a valid order and were provided pursuant to a current prescription. A review of youth records confirmed notifications to the DHA, psychiatrist, and parent/guardian were completed upon admission. The program utilizes a standard Department Medication Administration Record (MAR) which contains the youth's name, date of birth, allergies, precautions, medical grade, medical alerts, and start and stop dates. The MAR reflected staff initialed each administered medication entry and there were no lapses or errors in medication administration reflected. Nursing staff documented weekly side effect monitoring on the MAR. The Six Rights of Medication (right youth, right medication, right dose, right route, right time, and right documentation) were maintained by staff. One youth's MAR reflected refusals which were clearly documented on the MAR.

Observations reflected all medications were stored in a separate, secure area inaccessible to youth. All non-controlled medications were stored in a separate, secure area inaccessible to youth. Narcotics and other controlled medications were stored behind two locks. Oral medications were not stored with injectable or topical medications. The medical clinic has refrigerator with a lock for storage of medications requiring refrigeration. Syringes and sharps were secured. The medication cart was observed to be clean and organized, and stock items were separate from youth specific medications.

Medication pass was observed during the annual compliance review. Youth approached a window one at a time and the nurse confirmed the youth's name, dorm, and medication. The nurse provided the youth with the medication and afterward staff swabbed the youth's mouth to ensure the medicine was swallowed. When medications need to be disposed of due to expiring or discontinuation, the medications are disposed of in a pharmacy approved liquid when the consultant pharmacist is on-site monthly, and an additional witness is present. All seven interviewed youth confirmed the nurse provides youth with medication. Each of the seven interviewed youth stated the nurse provides their medication.

4.16 Medication/Sharps Inventory and Storage Process	Satisfactory Compliance
Any medical equipment classified as stock medications shall be secured and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed of or when the medication is utilized.	

Medical equipment classified as sharps, to include syringes, needles, scissors, and suture removal kits, were observed during the annual compliance review to be secured in the medical clinic and were inventoried utilizing a routine perpetual inventory descending count as each sharp was used and disposed. All medications were identified and secured in the locked area designated for storage of medications (medication cart and cabinets and drawers in the clinic were locked). Different medication forms were separated. All controlled substances had a perpetual inventory and were stored separately from other medications. Controlled substances

were also observed to be stored behind two locks with two separate key access. Documentation of the perpetual and weekly inventory of all sharps and stock over-the-counter (OTC) medication was reviewed, and no discrepancies were noted.

Documentation was reviewed of the shift-to-shit inventory count of all controlled substances documented on the youth's individualized controlled medication inventory record and no discrepancies were noted. Strict control and accountability of the running balance for each controlled substance is maintained. The number of pills remaining after each administered dosage was documented on the youth's individualized controlled medication inventory record. Two youth medications were inventoried, two of which were controlled medications. The count was accurate for each medication inventoried. Three OTC medications were inventoried, and no discrepancies were noted. Three sharps were also inventoried, and no discrepancies were noted. Program inventories for the past six months and the area designated to store sharps was reviewed. All medications are in a separate secure area inaccessible to youth. Narcotics and other controlled medications are stored behind two locks. Oral medications were not stored with injectable or topical medications. Syringes and sharps are secured. The medication cart is clean and organized. All medical equipment classified as sharps are secured and inventoried weekly using a routine perpetual inventory descending count as each sharp is utilized and disposed.

4.17 Infection Control – Surveillance, Screening, and Management	**Satisfactory Compliance**
The program shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The Comprehensive Education Plan is to include pre-service and in-service training for all staff. Education for youth infection control shall also be provided at the time of intake and subsequently when the need is identified.	

Infection control procedures are in place at the program to include prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The infection control procedures include common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C, Human Immunodeficiency Virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other anti-biotic resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures. Hepatitis B immunizations are available for all staff and staff have access to protective equipment. Documentation reflects standard universal precautions are followed by all staff. There was one instance in which it was necessary to notify the local health department, CDC, and/or the Central Communications Center of an infectious disease. The plan also includes provisions for needle stick post exposure evaluation. The program has a process to maintain all documents for youth or staff who have experienced a facility/occupational exposure.

The program's Exposure Control Plan is written in accordance with OSHA standards and is available to all staff. The facility administrator confirmed the plan is located in the staff breakroom, master control, and the policy and procedures book and is reviewed yearly. The exposure control plan includes a risk assessment and methods of compliance. There were not three or more cases of any reportable infectious disease which needed to be reported to the

local county health department or CDC. There were no instances involving quarantining or hospitalization of at least ten percent of the total youth population or staff.

4.18 Prenatal Care/Education	Non-Applicable
The program shall provide access to prenatal care for all pregnant youth. Health Education shall be provided to both youth and staff.	

This is an all-male program; therefore, this indicator rates as non-applicable.

4.19 Licensed Medical Staff (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

The program has licensed nurses to include on-site nursing coverage provided by a registered nurse (RN) and a licensed practical nurse (LPN). All nurses have clear and active licensure and current cardiopulmonary resuscitation (CPR) certifications.

Standard 5: Safety and Security

5.01 Youth Supervision	Satisfactory Compliance
Program staff shall maintain active supervision of youth, including interacting positively with youth, engaging in a full schedule of constructive activities, closely observing behavior of youth and changes in behavior, and consistently applying the program's behavior management system (BMS). Program staff can account for the whereabouts of youth under their supervision at all times.	

The program has a written policy and procedures addressing youth supervision. According to the written policy and procedures, program staff to youth ratios are one to six during awake hours, one to ten during sleep hours, and one to five for off-site activities, visitation, or when youth are separated from the population. The program's written policy and procedures define active supervision as the use of effective and efficient supervision, which includes positive contact, positive reinforcement, structured activities and random/predictable movement which provides suitable and timely response to the everyday needs of the youth and immediate response to emergencies while maintaining the safety and security of the program.

Observations of youth were made each day of the annual compliance review to include movement entering and exiting classrooms, youth movement to and from the living areas and cafeteria area, groups, and historical video surveillance footage. Staff to youth ratio was observed to be in compliance each day. Positive interactions were observed with staff and consistent application of the behavior management system was observed. Staff accurately reported the number of youth and ratios were met when asked. The daily activity schedule reflected a full schedule of activities planned. Observations of facility found the daily schedule was posted throughout the program to include the youth living areas. Staff appeared to be closely monitoring the youth under their supervision. At no time during the annual compliance review, youth were observed to be unaccompanied. Each of the seven interviewed staff explained what to do in the event a discrepancy in the count was found.

5.02 Comprehensive and Consistent Implementation of the Behavior Management System and Staff Training	Satisfactory Compliance
The program shall have a detailed written description of the collaborative behavior management system (BMS). The written description is conspicuously posted and provided in a resident handbook to allow easy access for youth, including rules governing conduct and positive and negative consequences for behavior including while in the classroom. *All staff shall be trained in the behavior management system (BMS) utilized at the program.*	

The program has a policy and procedures ensuring youth at the program are provided a safe therapeutic environment. The established behavior management system (BMS) is promoting positive social change and holding youth accountable for their behavior through behavioral expectations. The program's BMS is clearly written, posted throughout the program, and is included in the youth handbook.

A review of seven youth records revealed all contained, signed, and dated receipts of the orientation handbook. Observations throughout the annual compliance review reflected a consistent implementation of the BMS by staff to include adherence to the four to one ratio of positive to negative consequences. The youth's progression through the levels of the BMS is

indicated as orientation, recruit, rookie, pro, and all-star. Negative consequences are in direct relation to the severity or seriousness of inappropriate exhibited behavior. All seven interviewed youth explained the BMS system and the levels in which youth progress through the program. Five of the seven interviewed staff stated when youth are given behavior reports, the youth are given the opportunity to provide feedback in the comments section of the referral. Seven interviewed youth were able to explain the BMS level system. Five of the seven interviewed youth reported consequences could include getting "benched" for behavior reports and/or the loss of other incentives. The youth reported rewards include food, snacks, movies, games, and reward parties for completing certain goals.

5.03 Behavior Management System Infractions and System Monitoring	**Satisfactory Compliance**
The program's behavior management system (BMS) is designed to maintain order and security, provide constructive discipline and a system of positive and negative consequences to encourage youth to meet expectations for behavior, provide opportunities for positive reinforcement and recognition for accomplishments and positive behaviors, promote dialogue and peaceful conflict resolution, and minimize separation of youth from the general population. *Supervisors shall monitor staff implementation of the behavior management system (BMS), and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.*	

The program's written policy and procedures ensures a protocol in which staff are provided feedback regarding their implementation of the behavior management system (BMS). The assistant facility administrator (AFA), as the youth advocate, oversees the consistent implementation of the BMS by tracking documentation of consequences, reviewing any grievances, and listening to youth input. The BMS is tracked by the AFA through an excel spreadsheet. The spreadsheet contains a log of the total days earned for each youth, level status, behavior reports, and the status of earned days by date. Each week, youth level status sheets are posted in the dorms. Youth level sheets were observed to be posted in the dorms. An incentive calendar was also posted in the dorms. The BMS is reviewed in management team meetings and monthly campus-wide meetings for staff and teachers. Program position descriptions were available for review and revealed the required qualifications of staff whose job functions included implementation of the program's BMS. A review of the program's contract determined all required parties were involved in the development, implementation, and on-going maintenance of the BMS. The BMS allows staff to explain the reason for any sanction imposed on a youth and the youth is given an opportunity to explain their behavior. The BMS does not include increased length of stay, denial of basic youth rights, promotion of group punishment, punishment by other youth, or disciplinary confinement. The program does not use room restriction. Fourteen staff training records were reviewed for BMS training. Documentation reflected seven pre-service staff and seven in-service staff all received the appropriate BMS training.

All seven interviewed youth reported youth are not allowed to punish other youth. Six youth reported staff are consistent in the use of rewards. Three youth rated the BMS as good, three as fair, and one as poor. Six of the seven interviewed staff reported youth are given behavior reports for rule infractions and these infractions are discussed with the youth at the time. Six staff reported the BMS is discussed at briefings each day. According to the interim facility administrator, BMS violations are reviewed for consistency by the shift supervisor, the case manager, and the youth's therapist. Rewards are achieved and recognized through monthly and

weekly award ceremonies and incentives. Youth are also provided acknowledgements of “Do Rights,” which are given for good behavior and are worth points towards incentives.

5.04 Ten-Minute Checks (Critical)	Satisfactory Compliance
A residential commitment program shall ensure staff observe youth at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. Staff shall conduct the observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically.	

The program has twenty-two cameras, all of which were operational at the time of the annual compliance review. The program stores video footage for thirty days. The program currently has three staff shifts and there is one living unit where all youth in the program are housed. The program is required to complete room checks every ten minutes; however, it is the program’s practice to conduct room checks every eight minutes. Video surveillance footage was observed for three separate evenings. All three nights were observed for verification and accuracy of the ten-minute checks. All checks were observed to be completed, as required, and were documented in real time. In addition, staff were observed utilizing flashlights and going from room to room conducting youth checks. All seven interviewed staff reported room checks are to be conducted every eight minutes while youth are sleeping.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day. *The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.* *The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is feasible after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program has a policy and procedures regarding youth census, counts, and tracking. A review of logbooks for the past six months confirmed counts were completed during the approximate times specified in the policy. The logbooks documented proper counts were taken and cleared after a qualifying emergency, as well as periodic simulated drills to enable the implementation of proper count procedures. Logbooks documented new admissions, releases, and when youth were taken off-site. The youth headcount is also documented on the shift report log for briefing purposes. Several formal head counts were observed. Each count was controlled, accurate, and cleared without issues. Seven staff were interviewed, and all staff indicated a formal headcount is conducted every thirty minutes and after each youth movement. Additionally, all staff stated a count should be conducted after a disturbance and a recount after any discrepancy.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance
The program maintains a chronological record of events, incidents, and activities in a central log-book maintained at master control, living unit logbooks, or both, in accordance with Florida Administrative Code. The program ensures direct care staff, including each supervisor, are briefed when coming on duty.	

A review of the program's policies and procedures addressing logbooks and shift reports. A review of the logbooks for the previous six months revealed the overall appropriate utilization of the program logbook. Logbooks were pre-printed numbered pages with fields covering staffing, youth counts, movements, environment, drills, incidents (including Central Communications Center reports), emergencies, special instructions, perimeter and security checks, admissions and releases, and a chronological narrative for each shift. The logbook also contained a field for incoming staff to acknowledge their review of the previous shifts logs with their signature.

5.07 Key Control	Satisfactory Compliance
The program has a system in place to govern the control and use of keys including the following: • *Key assignment and usage including restrictions on usage* • *Inventory and tracking of keys* • *Secure storage of keys not in use* • *Procedures addressing missing or lost keys* • *Reporting and replacement of damaged keys*	

The program has a policy and procedures for key control address assignment of keys, tracking of keys, missing or lost keys, and reporting of and replacement of damaged keys. Training on key control has been provided to staff. Staff and visitors must turn in personal keys upon entering the program. A visual inspection was made of all four key storage locations. The visitor key storage is located in the administration building in the staff locker/copy room. Staff turn in personal keys to the master control operator and receive the assigned keys for the day, this process is reversed upon exiting the program. There is also locked key storage in the maintenance and medical offices. The issuance of each staff key is documented. Key box one contains all spare/duplicate keys, restricted keys, emergency keys, and is secured in a lock box in a locked office. The locked medical key box contains keys to the medication cart and over-the-counter medication and cold medication storage. A review of the key inventory found no discrepancies. Three sets of program key sets were observed and were found have the correct keys and the correct number of keys when compared to the inventory. Seven staff were interviewed, and each were aware to receive the keys they were required to and provide their personal keys and there is a daily tracking of keys. The program maintained a key control log for the keys being issued to the staff.

5.08 Contraband Procedure	Satisfactory Compliance

The program's policy must address illegal contraband and prohibited items.

A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.

The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.

The program has a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and youth, which is clearly explained in the program's policy and procedures, and resident handbook. The policy also states any staff who is found in possession of contraband in a program will be subject to disciplinary action up to, and including, dismissal, as well as procedures regarding notification of law enforcement for items considered illegal, as defined in Florida Statutes. The program defines items and materials considered contraband when found in the possession of youth, provides youth with a list of contraband, and informs youth of the consequences if found with contraband. The prohibited list includes personal cell phones and/or equipment and/or electronic devices capable of taking pictures and/or audio/video recordings, which are prohibited in the secure area. Staff were able to explain the contraband procedures. The contraband notice is posted on the gate at each entrance and states law enforcement will be contacted for anyone bringing in contraband. A random sample of program logbooks, youth search forms, and contraband logbooks were observed to verify youth room searches were conducted. A random selection of contraband searches were observed and compared to the program logbook. The program logbooks documented all observed contraband searches in the chronological narrative. Program logbooks included documentation of perimeter checks.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance

The program shall perform searches to ensure no contraband is being introduced into the facility.

The program has a written policy and procedures addressing searches. Observations during the annual compliance review found searches were completed prior to and after movement from one area to another. Video of a transport was reviewed and found searches were completed according to policy and procedures. Observations found searches were conducted in a manner which treated the youth with dignity and respect. Searches were conducted in accordance with Protective Action Response (PAR) training manual. All seven interviewed youth indicated searches occur after every movement or transition. Seven of seven interviewed staff reported searches are conducted before and after every movement.

5.10 Vehicles and Maintenance	Satisfactory Compliance
The program ensures any vehicle used by the program to transport youth is properly maintained, and maintains documentation on the use and maintenance of each vehicle. Each vehicle being used for transport of youth shall pass an annual safety inspection. Each vehicle used to transport youth is to be equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. Youth and staff wear seat belts during transportation, and youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.	

The program has a policy and procedures regarding vehicles and maintenance. The program has four transport vans. Two of the transport vans are no longer in use and have been surplused. Vehicle maintenance records and an annual inspection were documented for each of the two remaining vans in use. Each vehicle used to transport youth was visually inspected by the annual compliance review team member utilizing a vehicle checklist. Each van was equipped with all necessary safety equipment items including glass punch, seat belt cutter, fire extinguishers, and appropriate number of seatbelts. The program does not keep a sealed/unopened first aid kit in the transport van when unoccupied. A first aid kit is acquired from the main control room prior to departure.

5.11 Transportation of Youth	Satisfactory Compliance
Appropriate minimum staff to youth ratio shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a policy and procedures addressing transportation of youth. According to the program's policy and procedures, driver license checks are not conducted routinely for all program staff. According to the policy, it is the responsibility of the individual staff to notify their corresponding shift manager of any license suspension or revocation. Staff do not transport youth in personal vehicles and never allow youth to drive program or personal vehicles. A transport was observed utilizing video recording and determined policies and procedures were followed. A random inspection of staff personal vehicles was made and all were found to be secured. Each of the seven interviewed youth reported they had never observed anyone placing contraband into a program vehicle and each reported feeling safe when being transported by staff. All seven interviewed staff reported staff are not allowed to use personal vehicles for youth transports. All of the staff reported using cell phones and/or hand-held radios during youth transports.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
A program shall maintain a safe and secure physical plant, grounds, and perimeter.	

The program has a written policy and procedures ensuring the safe and efficient operation of the physical plant which protects against the development of conditions which may adversely affect the health, safety, and wellbeing of youth, staff, and visitors. The written policy and procedures outline the staff responsible for conducting the weekly security audits and safety inspections, the development and implementation or corrective actions warranted as a result of safety and security deficiencies found, and an internal system to verify deficiencies found are corrected. According to the written policy and procedures, the physical plant manager is responsible for conducting weekly safety audits. In addition, the physical plant manager will review the completed form with the facility administrator (FA) and have the FA sign and date the

audit form. A review of documentation confirmed the weekly audits were reviewed and actions required from the audits were reflected in maintenance service calls and meeting minutes. An interview with the FA indicated safety and security is addressed by the program during weekly safety and security audits, and daily perimeter checks on each shift. The program addresses the issues by setting target dates and working with the physical plant manager to correct the deficiencies, as well as contacting vendors if applicable. The program also discusses deficiencies during the morning meetings.

5.13 Tool Inventory and Management	Satisfactory Compliance
The facility shall have a tool management system ensuring youth do not use tools or equipment as weapons or security breaches.	

An inventory of the kitchen, operations, and the maintenance tools was conducted. During a review of the tool room, a random check from the official inventory list was conducted. There were no tools found to be missing or damaged. All tools observed were clearly identified with a tool number. The shadow board clearly outlined all tools with an identification number for the tool placed there. A review of the outside tool shed revealed there were no missing or damaged tools based on random selection of tools from the official tool inventory sheet. All tools in the tool shed and the tool room were properly documented by the staff signing out and signing in the tools utilized. There were no cooking tools or knives noted as missing or damaged. Each tool and/or knife was properly labeled with a tool number and all were accounted for. All tools were properly stored in a locked cabinet behind a locked door. A random check of tool inventory sheets reflected the program was properly documenting tool usage including the staff name/initials and the time the tools were signed out and returned. During a review of the program's tools, all tools were found to be secured and inaccessible to youth.

5.14 Youth Tool Handling and Supervision	Satisfactory Compliance
There shall be procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth, other youth, and staff.	

The program's policies and procedures address youth use of tools. Staff supervise youth at all times when youth use mops, brooms, or scrub brushes during cleaning activities. Youth are only permitted to use tools after receiving an intake risk assessment. Risk assessments and reassessments are completed for each youth by the case managers and are maintained in youth records. The risk assessment and reassessments include if youth are eligible to use tools. Youth whom have reached a specific level and have passes the risk assessment may use certain class A tools associated with program grounds maintenance.

Seven interviewed staff reported the tools youth are eligible to use are mops and brooms. Three staff reported youth could use scrub brushes. Seven youth were interviewed and all indicated they previously used mops and brooms. Five youth reported using a scrub brush. Four of the seven youth indicated youth may use screwdrivers and hammers, if youth are graduates and pass a risk assessment, to work with the physical plant manager. Two of those youth also reported youth can use a rake as well, if they pass the risk assessment.

5.15 Outside Contractors	Satisfactory Compliance
The program shall establish guidelines required for outside contractors, which includes information about tool control and restrictions.	

The program has a policy and procedures addressing protocols for outside contractors who perform work at the program. A review of documentation indicated written notifications and guidelines for outside contractors was signed by each contractor and inventory log is completed when outside contractors bring tools into the program. The inventory log is checked upon entry and exit to ensure the program and contractor can account for all tools utilized by outside contractors. A review of the program invoices reflected each contractor completed the required forms and equipment was accounted for.

5.16 Fire, Safety, and Evacuation Drills	Satisfactory Compliance
The program shall conduct fire, safety and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster.	

The specific procedures for fire, safety, and evacuation are outlined in the program's Department approved Continuity of Operations Plan (COOP). The program conducts drills to prepare for immediate implementation or mobilization of the COOP whenever an emergency arises. The program conducts fire, safety, evacuation, program disturbances, and disaster drills. The documentation for drills included the type of drill, date and time, participants, brief scenario, and findings to include recommendations. The program currently has three shifts. In the previous six months, the program completed three monthly fire drills with varying conditions and across all shifts. Fire evacuation routes and egress plans were observed posted throughout the program. Seven interviewed staff reported they have participated in the weather, major disturbance, bomb threat, hostage situation, chemical spills, flooding, terrorism, escape, and fire drills. Seven interviewed youth reported they have been instructed on what to do in case of a fire. All of the youth reported fire drills are conducted at least monthly.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature. *A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.*	

The program has a coordinated disaster plan and Continuity of Operations Plan (COOP). The plan provides for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned while ensuring the safety of staff, youth, and the public. The COOP is conspicuously posted in the program, readily available to staff, youth, and visitors, and disseminated to appropriate local authorities. Observations and an interview with the facility administrator (FA) confirmed copies of the COOP are located in master control, the facility administrator's (FA) office, and the staff break room. The COOP is reviewed and updated annually and was submitted to and signed by the Department's residential regional

director/designee on March 25, 2020. The program maintains a binder of critical identifying information and a current photograph of each youth to verify identity, if needed.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program director or designee shall maintain strict control of flammable, poisonous and toxic items and materials and a complete inventory of all such items.	

The program has a written policy and procedures addressing the storage and inventory of flammable, poisonous, and toxic items and materials. The policy also addresses issuance and accessibility of the different chemical types based on their flammability, poisonous, or toxic items and materials. The policy addresses procedures for certain hazardous chemicals only handled by specifically identified personnel with proper training. All general cleaning chemicals for the kitchen and youth dorm were stored in separate secured closets with complete and accurate inventory sign-out sheets. Maintenance utilizes a cart which holds cleaning products, which is stored in the maintenance shed and inaccessible to youth without supervision. All surplus cleaning chemicals for the kitchen and youth dorm were securely stored in a storage closet inaccessible to youth. All surplus chemicals were properly/accurately inventoried with proper documentation supporting the use of surplus as it was checked out or utilized. Each chemical contained Safety Data Sheets along with an individualized chemical inventory sheet. A review of the secured outside storage shed inaccessible to youth contained additional flammable chemicals, paints, oils, and miscellaneous chemicals.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.* *The program shall establish and implement cleaning schedules, a pest control system, a garbage removal system, and a facility maintenance system which shall include maintenance schedules and timely repairs based on visual and manual inspections of the facility structure, grounds, and equipment, which shall be conducted bi-weekly, monthly, quarterly, semi-annually, yearly, and every three years, as prescribed in the Preventive Maintenance Checklist (RS 123, February 2019.*	

The program has a policy and procedures prohibiting youth from handling flammable, poisonous, or toxic items. The program's facility plant manager is the only staff authorized to handle and dispose of flammable, poisonous, and toxic items. Procedures are in place for the supervision of youth who assist in cleaning activities requiring staff to maintain control of any cleaning agents used. Observations and documentation reviewed found youth did not handle any toxic or cleaning items. A biohazard spill kit is stored in a secured area not accessible to youth and in the same area where the program deposits the bio-hazard waste in the bio-hazard waste bins. Seven interviewed youth indicated youth did not clean up blood, bodily fluids, chemicals, or bio-hazardous materials. Two youth stated staff handle all cleaning chemicals and the youth wipe down the surfaces.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The maintenance personnel, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials.	

The program's policies and procedures address the disposal of flammable, poisonous, and toxic items. There were no incidents of chemical spills for the annual compliance review period. Mop water and excess kitchen fluids are disposed in plumbing drains. The program does not purchase or use cooking grease for cooking purposes at any time. An interview with the facility plant manager found chemical disposal practices were in accordance with disposal instructions listed on Material Safety Data Sheets (MSDS) or safety data sheets (SDS). Program utilizes the local landfill for disposal of all flammable, poisonous, and toxic items.

5.21 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Non-Applicable
Programs choosing to participate in water-related activities shall develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. The plan shall also ensure staff are appropriately trained for each specific type of water activity. *Programs allowing youth to participate in water-related activities shall have a water safety plan addressing, at a minimum, safety issues, emergency procedures, and the rules to be followed during water-related activities, as follows:* • *Determination of the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues, and physical stature and conditioning;* • *Type of water, such as pool or open water;* • *Water conditions, such as clarity, turbulence, and bottom conditions;* • *Type of activity, such as swimming, boating, canoeing, rafting, snorkeling, scuba diving, and shoreline and offshore activities to include fishing from a bank or pier, fishing while wading, or picnicking close to a body of water.* • *Lifeguard-to-youth ratio and positioning of lifeguards;* • *Other staff supervision; and* • *Safety equipment needed for the activity, such as personal flotation devices when youth are in a boat, canoe, or raft, and availability of a lifeline during shoreline and offshore activities.* *Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.* *Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.*	

The program does not participate in water activities; therefore, this indicator is not applicable.

5.22 Visitation and Communication	Satisfactory Compliance
The program allows visitation and communication for youth while in the program.	

The program has written established procedures by which the program may provide youth with opportunities to re-establish and maintain family and community ties to be involved in first person communications with attorneys and their agents, approved law enforcement, court and Department staff, and to ensure control of community access to the program. The program's activity schedule reflects visitation is held every Sunday from 2:30 p.m. to 5:30 p.m. Parents/guardians are mailed the program's procedures for visitation, mail, and phone usage upon the youth's admission to the program. The visitation log was available for review. The visitation log reflected the visitor's name, whether they were an approved visitor, signature, time in and time out, identification check, rules provided, searched completed, and the initials of the staff completing the log.

At the time of annual compliance review, the program suspended in-person visitation due to the COVID-19 pandemic. The written policy and procedures reflect only the facility administrator may approve special visits. Youth are allowed to make telephone calls once a week and calls are facilitated by the youth's case manager. Observations found the telephone call schedules were posted in each dorm. Phone calls begin after the youth are released from school. Telephone calls are initially ten minutes for each youth and can increase with level achievement or for a reward, up to thirty minutes. Telephone call logs were available for review and included the individual whom the youth was contacting, whether the call was successful, and the youth and staff initials. Youth are permitted to send and receive letters to those individuals on their approved correspondence list. All incoming and outgoing mail is searched by the youth's case manager. Seven interviewed youth reported they have been able to communicate with their families by telephone and letters.

5.23 Search and Inspection of Controlled Observation Room	Non-Applicable
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program does not utilize controlled observation; therefore, this indicator is not applicable.

5.24 Controlled Observation	Non-Applicable
Programs shall only place youth in Controlled Observation when non-physical interventions would not be effective.	

The program does not utilize controlled observation; therefore, this indicator is not applicable.

5.25 Controlled Observation Safety Checks Release Procedures	Non-Applicable
The program shall conduct safety checks for youth on Controlled Observation. The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.	

The program does not utilize controlled observation; therefore, this indicator is not applicable.